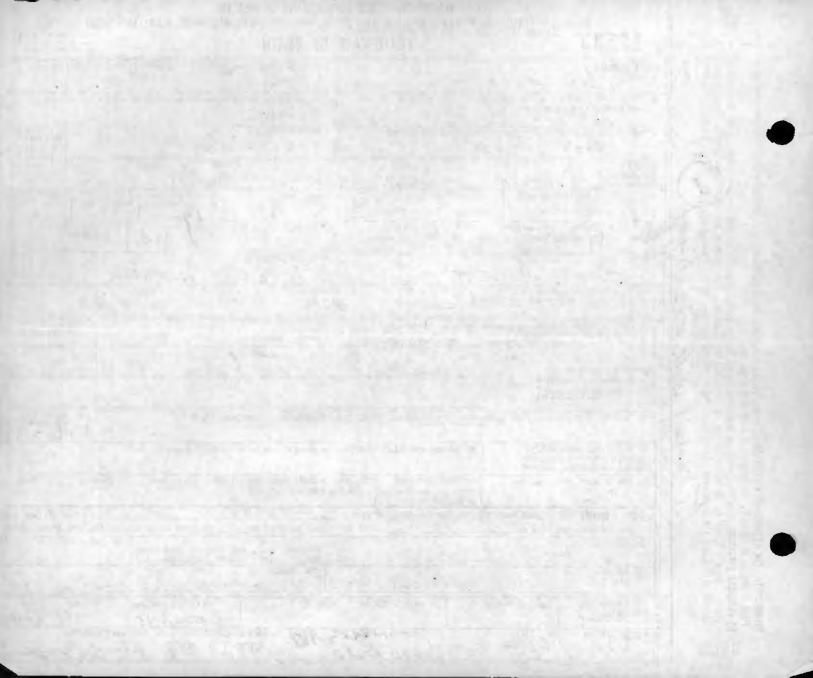
1		Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRES  12533 CERTIFICATE OF D	NT OF HEALTH STON STREET, BALTIMORE, MARYLAND 2120 DEATH	12543
funeral fond fer death		COUNTY NONTSOMERY MARYLAND O. STATI	I'll Pr.	Geo.
hours after thours after hours after thours after thousafter thous		write RURAL and give necress town	TOWN (If outside corporate limits, write RURAL and give n Laurel	14.2
illed in popers.		NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress)  d. STREET	HENFIELD GURT	e. IS RESIDENCE ON A FARM? YES NO
pletely with		AME OF ECEASED   DEBORAH LYNN ALBO	OF DEATH SEPT 1	Doy Year 7
execution and camp any even	5.	1 WIDOWED DIVORCED 1 6/2	3/66   Nonths D	oys Hours Min.
cate be exe	dui	a most of working life, of earth retired) INDUSTRY	PYACE (County & State, or foreign/country)  A. 12. CITIZE COUN  ER'S-MAIDEN NAME	IRY?
e death certificate be executed within 24 ho aftending physician and campletely filled in permit. Then please removes control appers.		WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT	ERESSA MERRICK	
attend permit.	(Ye	, no, or unknown) [If yes give wer or dotes of service) #13	#2	INTERVAL BETWEEN
physician. signed by the attendibution, crematian, crem		18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).  PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a)  DUE TO	when	ONSET AND DEATH
Page 4 may be retained by the haspital or attending physician.  To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 should be detached far use as the burial-transit permit. Then please remove certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 should be detached far use as the burial-transit permit. Then please remove certified and pagers. Pages had should be filed with the State Dept. at Health priar to burial, crematian-ar removal, and in any event, whim 72 hours after death		Conditions, if any, which gove rise to immediate cause (a), storing the underlying cause last.  (b) Muscular Myp  DUE TO  (c)	Mysty	
	ATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL	L DISEASE CONDITION GIVEN IN PART 1(0)	19. WAS AUTOPSY PERFORMED? YES NO
	L CERTIFIC	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature or contributing (I cause of death (IF either, notify medical examiner)		
NC PH v the h v the h	MEDICAL	20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. 19 2Dd. INJURY OCCURRED While Not While of work 19 foctory, street, of	fice bldg., etc.)	
TTENDI ained b OR: Aff		21. I certify that (I) (this haspital) attended the deceased from Saw the deceased alive an 13 1967, and that death at 220. SIGNATURE		
L OR A DIRECT DIRECT SIGN SIGN SIGN SIGN SIGN SIGN SIGN SIGN		alfut Molle 30 2 M.O. PHYS.	ING MED STAFE	14-67
O HOSPITAL Page 4 may O FUNERAL I director, pag should be fil	230	NAME (Type) It BERT I POOLIN BO TO	23d. LOCATION (City or Town) (Co	unity) (Stote)
	24	BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY REMOVAL (Specify)  JUNEAL DIRECTOR ADDRESS A LETE, AND	SPOKANE  250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGN	WASHI
VR A15 (4) . 20 M 1/66		CAMPAN SEOWASH BIND	DATE SEP 19 1967 yelland	y Judge



MARYLAND STATE DEPARTMENT OF HEALTH

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**ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 haurs after death

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12548

CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY Montgomery Maryland MARYLAND b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY DR TOWN (If autside carparate limits, write RURAL and give negrest town) Bethesda (Rural) 1 Hour Silver Springs d. NAME OF HOSPITAL DR INSTITUTION (If nat in haspital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? U. S. Naval Hospital, Bethesda, 8201 16th Street NO X 3. NAME OF First Middle 4. DATE Month Last Day Year DECEASED September BADT 8th 19 67 Harry Asher (Type or print) DEATH 9. AGE (In years IF UNDER 24 HRS S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH IF UNDER I YEAR 82 last birthdoy) 22 SEP 1884 Months Hours Male Caucasian WIDOWED DIVDRCED 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
U. S. Navy 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) USA COUNTRY? INDUSTRY TYLER TEXAS N/A 13. FATHER'S NAME Joseph BADT 14. MOTHER'S MAIDEN NAME IDA SPIRO IS. WAS DECEASED EVER IN U.S. ARMED FORCES? AddresSilver Springs. 16. SDCIAL SECURITY NO. 17. INFORMANT Yes, na, or unknown) (If yes give war ar dates of service)
Yes 10 MAY1904-Apr 16th St. 578-40-9963 Jennie (NMN) BADT 8201 Md. 18. CAUSE OF DEATH (Enter only one course per Acute Myocadial Infarction INTERVAL BETWEEN PART 1. DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (a) DUF TO Advanced Coronary Arterisclerosis Conditions, if any, which gave rise to immediate cause (a), DUF TO stating the underlying cause last. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE NO 200. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I at Part II af item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE DF INJURY (Hame, form, (City or town) (County) (State) 20c, TIME DF INJURY Month, Day, Year Hour 'a.m. factory, street, affice bldg., etc.) 1967, that (4) (we) last 21. I certify that (1) (this hospital) attended the deceased from sow the deceased glive on SEP 8 SEP and that death accurred at 7:21PM, from causes and on the date stated above. sow the deceased alive on 19 67 220. SIGNATURE 22b. DATE SIGNED STAFF PHYS. DIRECTOR PHYS S. Navl Hospith, Bethesda, Md. 22c. PHYSICIAN'S D.R. FOREMAN NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23a. BURIAL, CREMATION 23b. DATE THEREOF Virginia DE 4044 (Specif Arlington, National Arlington. 12 SEP 1967 2So. REC'D BY REGISTRAR

Page 4 may be retained by the haspital ar attending physician. director, page 3 shauld shauld be filed with the TO FUNERAL

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DIRECTOR:

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12538 12547 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) g. COLINTY 5 COLINTY MARYLAND c. LENGTH OF STAY IN 16 c (ITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) 3weeks ngTon d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS SANITARIUM TARdens NAME OF Middle remove carban DECEASED SepTemBer BAILEY ances BAHN 10 5 SEX AGE (In years 7 MARRIED NEVER MARRIED Months Days DIVORCED WIDOWED crematian, ar remaval, and in afr 10a USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State or foreign country) 12 CIT ZEN OF WHAT during most of working life, even if retired) INDUSTRY PENNA HousewiFe 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME 17 INFORMAN (Yes, no, or unknown) (If yes give war ar dates of service) 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), DUE TO stating the underlying cause 3 should be detached far use as the with the State Dept. of Health priar to WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN MIPART I(a) NO 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 8) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Hame, farm, (County) (State) 20d. INJURY OCCURRED (City or town) 20c. TIME OF INJURY Month, Day, Year Haur a.m. factory, street, affice bldg, etc.) Not While 21. I certify that (h) (this baspital) aftended the deceased fram 19 6 Z. ta I that (1) (we) last 1967, and that death accurred at 1:30 AM, from causes and on the date stated above FUNERAL DIRECTOR: saw the degeased alive an 22b DAY SIGNED 22a SIGNATURE director, page 3 shavid be filed v M.D. DIRECTOR PHYS PHYS. 22d. ADDRESS PHYSICIAN'S NAME (Type) NW 23d. LOCATION (City or Town) (State) ((aunty) 2 REGISTRAR S SIGNATURE VR A15 (4) 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12533 12549 CERTIFICATE OF DEATH 24 haurs ofter death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceosed lived, if institution. Residence before admission) Montgomery o STATE 6 COUNTY MARYLAND Maryland Montgomery b CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town)
Takoma Park E LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) 3 days Ellicott City d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS IS REJUDENCE ON A FARM? Washington Sanitarium and Hospital 12 Macgill YES NO F Avenue requires that the death certificate be executed within NAME OF 4. DATE Month Year 31333 (Type or pnnt) Mackey Baliles DEATH Lee September S SEX 6 COLOR OR RACE IF JNDER I YEAR 7. MARRIED [20] **NEVER MARRIED** B. DATE OF BIRTH AGE (In years lost birthdoy) Months Doys Hours 5-13-97 white buriol-tronsit permit. Then please remo buriol, cremation, or removal, and in ony Male MIDOWED DIVORCED 100 USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY **COUNTRY?** D.C. Transit-retired Virginia MOTHERS MAIDEN NAME America 13. FATHER'S NAME ottending p Barnev Baliles Lucinda Folev WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMAN 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dates of service) 578-10-5979h Patinet\*s chaft IB. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c) ) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) signed by by the hospital or affending physician. DUE TO Conditions, if ony, which gove ) use to immediate couse (a). DUE TO stating the underlying cause hos been etached for use as the Dept of Health prior ta PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) WAS AUTOPS!
PERFORMED? YES NO certificote CERTIFICATI 200 ACC DENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 11 of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (Cty or town) (County) (Stote) 10 FUNERAL DIRECTOR: After this Hour a.m. foctory, street, office bldg., etc.) Not While be de State l ATTENDING at work 21. I certify that((1) (this hospital) attended the deceased from Poge 4 moy be retained and that death accurred at 3.42 A.M. fram causes and an the date stated above saw the deceased alive an 220 SIGNATURE DIRECTOR M.D. director, poge should be filled 22d ADDRESS 22c. PHYSICIAN'S NAME (Type) DATE THEREOF 23c NAME OF CEMENTRY OR CREMATORY 230 BURIAL, CREMATION, 23d. LOCATION (City or Town) (County) (Stote) **BEMOVAL** (Specify) 24/1 FUNERAL DIRECTOR BY REGISTRAR 2Sb REGISTRAR'S SIGNATURE 250 REC M A15 (4)





DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. be retained by the haspital or attending physician. 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) PLACE OF DEATH o. COUNTY o. STATE b. COUNTY Montgomerv South Carolina MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 16 filled in by t Bethesda 28 Days Florence d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oudress) o IS RESIDENCE ON A FARM? d. STREET ADDRESS The Clinical Center, Bethesda, Marvland YES NO TO 552 Santiago Drive Midd.e 4 DATE Month DECEASED Barefoot, Jr. DEATH Lerov Hugh September 19 19 67 9. AGE (In years S SEX 6. COLOR OR RACE IF UNDER 1 YEAR 7 MARRIED B. DATE OF BIRTH JE JINDER 24 HRS NEVER MARRIED lost birthdov) Months White WIDOWED DIVORCED Male 13 April 1966 100 USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CIT ZEN OF WHAT during most of working life, even if retired) COUNTRY? INDUSTRY South Carolina USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME or removal. Leroy H. Barefoot, Sr Patricia Harvey 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17 INFORMANT The Medical Recodes (Yes, no, or unknown) (If yes give wor or dates of service) None The Clinical Center, Bethesda, Maryland IB. CAUSE OF DEATH (Enter only one couse per Hine For (o), (b), and (c))
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN 1 ONSET AND DEATH IMMEDIATE (AUSE (6) Congenital Heart Disease DUF TO Conditions, if ony, which gave (b) rise to immediate couse (o), DUE TO stoting the underlying couse this certificate has been PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19 WAS AUTOPSY PERFORMED? YES TAL NO T 20g ACCIDENT WAS UNDERLYING [7] 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port 1 of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) foctory, street, office bldg. etc.) Not While **DIRECTOR:** After 21. I certify that (A) (this haspital) attended the deceased from 22 August, 19 67, to 19 Sept., 1967, that (X) (we) lost sow the deceased alive on 19 Sept., 19 67, and that death occurred at 22.07 M, from causes and on the date stated above 220 SLONATURE MED. PM STAFF 22b DATE SIGNED 22c PHYSICIAN'S 22d ADDRESS The Clinical Center, National TO FUNERAL Lynn M. Peterson, M. D. of Health, Bethesda, Md. 23c NAME OF CEMETERY OR CREMATORY 230 BUR AL, CREMATION, 23b DATE THEREOF 23d LOCATION (City or Town) (County) Purial-transit 9-20-67 Mt. Hope Cemetery Florence, So. Carolina 256 REGISTRAR'S SIGNATURE 250 REC D BY REGISTRAR DATE SEP 2 5 ADDRESS VR A15 (4) 25M 1/67 PIMPHRET, Bethesda, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12542 12551 CERTIFICATE OF DEATH The low requires that the death certificate be executed within 24 hours ofter deoth. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY b. COUNTY MARYLAND ONIGOMORINO b. CITY OR TOWN (If outside corporate limits. t. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town completely filled in by ove carbon papers. Po d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitos, give street oddress) d. STREET ADDRESS IS RESIDENCE ON A FARM? antarium NO X YES of, with 3. NAME OF Middle Lost DATE Year DECEASED OF DEATH (Type or print) arr S. SEX MARRIED VI 6 COLOR OR RACE DATE OF BIRTH AGE (In years IF UNDER TYEAR IF LINDER 24 HRS NEVER MARRIED burial, cremation, or removal, and in any eve remove lost birthdoy) Months Doys Hours WIDOWED DIVORCED puo 10b. KIND OF BUSINESS OR 10c USUAL OCCUPATION (Give kind of work done 12 CIT ZEN OF WHAT 11. BIRTHPLACE (County & State or foreign country) during most of working life, even if retired) COUNTRY? 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ottending phys permit. Then p 15. WAS DECEASED EVER IN U.S. ARMED FORCES? INFORMAN' 16 SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give wor or dotes of service) 1B. CAUSE OF DEATH (Enter only one cause per line for (a), NTERVAL BETWEEN the signed by the burial-transit PART 1. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) Page 4 may be retained by the hospital or attending physician. DUE TO Conditions, if ony, which gove rise to immediate cause (a). DUE TO stoting the underlying couse certificate hos been director, page 3 should be detached for use as the should be filed with the Stote Dept. of Health prior to 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO 200 ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port or Port II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour o.m. foctory, street, office bldg., etc.) Not While OR ATTENDING at work at work TO FUNERAL DIRECTOR: After 2). I certify that (I) (this hospital) attended the deceased from sow the deceased alive on. M. from causes and on the date stated above 19 6 and that death accurred at 220. AGNATURE 226. DATE SIGNED STAFF DIRECTOR M.D. PHYS 22d ADDRESS PHYSICIAN'S NAME (Type) JOSE 230 BURIAL, CREMATION NAME OF CEMETERY OR CREMATORY 23da LOCATION (City or Jown) 23b. DATE THEREOF (County) 24. FUNERAL DIRECTOR VR A15 (4) 25M 1/67

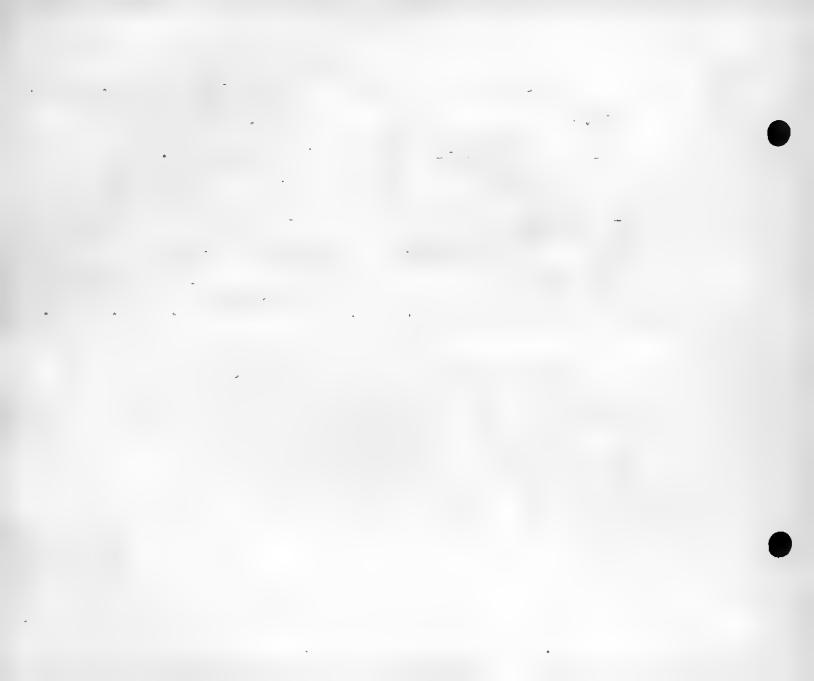




MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 12544 The low requires that the death certificate be executed within 24 hours after deaths 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) 1. PLACE OF DEATH o COUNTY o STATE b. COUNTY Montgomery
b (ITY OR TOWN (It dutside corporate limits, write RURAL and give nearest town)
ROCKVILLE Maryland hours after MARYLAND Montgomery the attending physicion and completely filled in by the fisst permit. Then please remove category papers. Pages c CITY OR TOWN (If autside carporate limits, write RURAL and give nearest tawn) CLENGTH OF STAY IN 16 Rockville d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. IS RESIDENCE d. STREET ADDRESS ON A FARM 13516 Glen Mill Road 13516 Glen Mill Road KOKON WIT. First 4 DATE NAME OF Lost Doy Year DECEASED William Sept. 13. 67 W. Bartlow 39 (Type or print) DEATH 9 AGE ( n years IF UNDER 1 YEAR IF UNDER 24 HRS. sex Male 6 COLOR OR RACE 8 DATE OF BIRTH 7 MARRIED NEVER MARRIED 8 (ast birthday) Months Nov.6,1880 Doys Haurs cremation, or removal, and in any WIDOWED DIVORCED 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT 10a JSUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR during most of working life, even if retired) COUNTRY? INDUSTRY Pennsylvania USA 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME Richard Bartlow Mary Bardl 16. SOCIAL SECURITY NO. 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) 186-01-5516 Mrs Russell Sweeney-Item # 2 INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) signed by the buriol-tronsit p ONSET AND DEATH PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (0) Myocardial infarction Poge 4 may be retained by the hospital or ottending physicion DUE TO buriol. Arteriosclerotic heart disease Conditions, if any, which gave Many yrs. rise to immediate cause (a), DUE TO stating the underlying cause os the prior to TO FUNERAL DIRECTOR: After this certificate has been 19 WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) for use Heolth NO J Diabetes; cerebral arterisclerosis; old fractured hip. pulm. fibrosis YES T 20a ACCIDENT WAS UNDERLYING 205. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I at Part II af item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) (State) 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, form, (City or town) (County) 20c. TIME OF INJURY Month, Doy, Year factory, street, affice bldg., etc.) Nat While ot work at work 21. I certify that (1) (this haspital) attended the deceased from Oct/ 11 , 1965, ta Sept. 13, 1967, that (I) (we) last 3 should by with the S saw the deceased olive on July 20. 19 67, and that deoth occurred of a M, from couses ond on the date stated above 22b DATE SIGNED 22a. SIGNATURE **ATTENDING**  $\mathbf{x}$ Sept. 13, 1967 DIRECTOR PHYS. M.D. PHYS director, poge should be filed ADDRESS 22c PHYSICIAN'S NAME (Type) Sydney Cohen Edmondston Drive, Rockville, Md 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (State) 230 BURIAL, CREMATION. REMOVAL (Specify)
Burial Rose Lawn Rerwick, Pennsylvania 9/16/67 2Sb. REGISTRAR S SIGNATURE ler Funeral Home-1331 Rockville Pike 2Sq REC'D BY REGISTRAR VR A15 (4) 20 M 1/66 Ochanias Judy 5 196 Rockville, Maryland



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 1255 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEPT. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institut an Residence before admirption) o (D. NIY b. COUNTY Montgomery Maryland MARYLAND Pr. George's delay b CTY DR TDWN (If outside corporate limits, write RURAL and give nearest lawn) c CITY DR TOWN (1) outside carparate limits, write RURA, and give nearest town) C LENGTH DE STAY N 16 Mt. Rainier Silver Spring DOA d NAME OF HDSP TAL DR INSTITUTION ( finat in hospital, give street address) B IS RESIDENCE ON A FARM? d STREET ADDRESS icate, writing the ward 'pending' in pencil in Item 18. Give Pages 1, be farwarded to the Chief Medical Examiner's Office along with farm 4314 Kaywood Dr. Holy Cross Hospital ND 😿 This certificate shauld be executed within 24 hours after death. NAME OF Middle 4 DATE Year DECEASED (Type or print) Philip Bath DEATH September 7
GE 'In years IF UNDER 1 YEAR Henry 5 SEX 6 CDLDR DR RACE IF UNDER 24 HRS 7. MARR ED NEVER MARRIED last birthday) Months Days Hours DIVDRCED and in any event within 72 hours after death Male White W DDWED 11/10/00 100 \_SUAL DCCUPAT DN (Give kind all work done during most of working life, even if refired)
Plumber 106 KIND DE BUSINESS DR 11 BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT COUNTRY? INDUSTRY Pittston, Penna. Plumbing 13. FATHER'S NAME 14. MDTHER'S MAIDEN NAME unknown William Bath (died at birth) IS WAS DECEASED EVER IN U.S. ARMED EURCES? 16 SOCIAL SECURITY NO Daugther. (Yes, no, or unknown) (If yes give war or dates of service) W.W. 07 80 12814 Turkey Br. Pkwy. R vl. Yes 18 CAUSE OF DEATH (Enter only one cause per line for (a) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), DUE TD stating the underlying cause PART II DTHER'S GNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(G) 19 WAS AUTOPSY PERFORMED? remayal ND 20g EXTERNAL CAUSE WAS 20b. DESCRIBE HDW INJURY DCCURRED (Enter nature of njury in Part or Port 11 of item 18.) PRIMARY CLOT CONTRIBUTING C CALISE DE DEATH MEDICAL 20c TiME DF NoRY Month Day Year 20d INJURY DCCURRED 20e PLACE DE INJURY (Hame form 20f (City or town) (County) Hour a.m factory, street, affice bldg, etc.) 2). I certify that I taok charge of the remains described above held an Autopsy Inspection 1 Inquiry and in my apinian may be retained far FUNERAL DIRECTOR: Natural causes Accident death resulted fram Undefermined manner Suicide [] Hamicide CHIEF MED CAL EXAMINER 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER 23b DATE THERED! 23a LDCATION (City or Town) 230 BUR AT CREMATION. Suitland Pro Georges Cedar Hill Cemetery Md. Sept 11, 1967 24 FUNERAL DIRECTOR 25g REC'D BY REGISTRAR 2Sb REGISTRAR'S SIGNATURE VR ATSME F. Gasch's Sons Hyattsville, Md. 6M 1/6





MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12547 12556 CERTIFICATE OF DEATH PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o STATE b. COUNTY MARYLAND b CITY OR TOWN (It outside corporate limits LENGTH OF STAY IN 16 c CITY OR TOWN (If autside carparate limits, write RURAL and a ve negrest town write RURAL and give negrest .= d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) B IS RES DENCE ON A FARM? d STREET ADDRESS campletely filled NO K YES NAME OF Middle DATE Last Manth Year DECEASED OF. (Type or print) DEATH 19 SEX 6. COLOR OR RACE AGE (In years last birthday) IF JNDER YFAR IF UNDER 24 HRS 7 MARRIED NEVER MARRIED 8. DATE OF BIRTH 図 Months Days Haurs and in any WIDOWED DIVORCED 10a USUAL OCCUPATION (Give kind of work dane 10b KIND OF BUSINESS OR 11. BIRTHPLACE/County & State, or foreign/country) 1/2 CITIZEN OF WHAT physician on please during most of working life, even if retired) INDUSTRY COUNTRY? 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME remayal, attending presents. The WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT Address (Yes, no, ar unknown) (If yes give wor or dates of service) CAUSE OF DEATH (Enter any one cause per fine for (a), (b), gad (c).) INTERVAL BETWEEN ONSET AND DEATH signed by the burial-transit cremai PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (o) **IO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires the Page 4 may be retained by the haspital or attending physician. DUE TO this certificate has been signed Conditions, if any, which gave rise to immediate cause (o) DUE TO stating the underlying cause as the lost. 19 WAS AUTOPSY PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? USe YES T NO ģ 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20a ACCIDENT WAS UNDERLYING ... be detached to State Dept. af OR CONTRIBUTING 

CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (State) Nat While foctory, street, office bldg etc.) at wark TO FUNERAL DIRECTOR: After spitol) attended the deceosed from. 1966,10 21 I certify that (1) 4this 1967 that (1) (we) last 19 67, and that death accurred at 4000 M, fram causes and on the date stated obove saw the decorred alive a filed with 220. SIGNATURE 22b DATE SIGNED ATTENDING M.D DIRECTOR PHYS. , page be filed 22d. ADDRESS 22c. PHYSICIANS NAME (Type) لر لان UNR director, should b 230 BUR AL, CREMAT ON, 23b DATE THEREOF 2369 NAME OF CEMETERY OR CREMAJORY 23d LOCAT ON (City or Town) (County) (Stote) OREMOVAL (Specify) HILL COMETER UITLAND 256 REGISTRAR'S SIGNATURE DATE SEP 24 FUNERAL DIRECTOR. VR A15 (4)







MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12551 12580 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) n. COUNTY a. STATE b. COUNTY Montgomery MARYLAND Georgia b CITY OR TOWN (If autside corporete limits, write RURAL and give neorest town) CLENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ián papers. Pag within 72 haurs 150 days Blakely Bethesda d. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital, give street address) 20014 .⊑ d STREET ADDRESS B IS RESIDENCE ON A FARM? filled i The Clinical Center, Bethesda, Maryland Route 1 Box YES 🗔 NO 5 NAME OF First 4. DATE Month Year DECEASED John September Henry Blakelv DEATH 19 67 S. SEX 6. COLOR OR RACE AGE (In years lost birthday) IF JNDER YEAR IF UNDER 24 HRS NEVER MARRIED 8 DATE OF BIRTH 7 MARRIED Hours and co Male White WIDOWED DIVORCED 28 May 1960 10a USUA, OCCUPATION (Give kind of work done during toos) of working life even if retired)
United (None) 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT Ξ. COUNTRY? U.S.A INDUSTRY Georgia 14 MOTHER'S MAIDEN NAME 13 FATHER S NAME removal. Carl Blakely Carol Erenheim TS WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT The Medical Records (Yes no, ar unknawn) (If yes give war ar dates af service) Ь The Clinical Center, Bethesda, Maryland 2001 None INTERVAL BETWEEN 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c))
PART I DEATH WAS CAUSED BY:
PRICE TO THE TOTAL TOTAL THE COURSE OF THE TOTAL ANSET AND DEATH Bilateral bronchopneumonia IMMEDIATE CAUSE (o) DUE TO Acute Myelogenous Leukemia Conditions, if any, which gove years rise to immediate couse (a). DUE TO stoting the underlying couse O HOSPITAL OR ATTENDING PHYSICIAN: The law re Page 4 may be retained by the haspital ar attending After this certificate has been PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19 WAS AUTOPSY PERFORMED? YES 🔽 NO 20o ACCIDENT WAS JNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of Item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e. PLACE OF INJJRY (Home, farm, (City or town) (County) (State) Not While factory, street, office blda., etc.) of wark of work 21. I certify that (M (this haspital) attended the deceased from April 24. . 19 67, to Sept. 21, 1967, that \$8 (we) last FUNERAL DIRECTOR: saw the deceased alive any Sept. 21. 19 67, and that death accurred at 10.20M, from couses and an the date stated above 220 SIGNATURE 22b DATE SIGNED STAFF PHYS. 🔀 21 Sept. 1967 M,D DIRECTOR 22d. ADDRESS The Clinical Center, National 22c. PHYSICIAN'S NAME (Type) F. Carl Grumet. MD Institutes of Health, Bethesda, Md. 2001 230 BURIA CREMATION, REMOVAL (Specify) 23d LOCATION (City or Town). 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY (County) (Stote) 2 **ADDRESS** 25o REC'D BY REGISTRAR 25b REG STRAR S SIGNAFORE **FUNERAL DIRECTOR** VR A15 (4) DATE SEP 26 1967 Charica, Judge MEXICA Salvable 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTIN Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where dec lived, if institution. Residence before admission) COUNTY o. STATE b. COUNTY Maryland Montgomer (CITY OR TOWN (If outside corporate limits, write RURAL and give mearest town) MARYLAND montanmers filled in by the fi CITY OR TOWN (If outside corporate limits. TENGTH OF STAY IN 15 write RURAL and give nearest town) hours Spring rrban papers. d. NAME OF HOSPITAL OR INSTITUTION (If not an hospital, give street address) d. STREET ADDRESS ON A FARM? YES [ NO X 3. NAME OF DATE First Middle physician and completely DECEASED OF Blendma (Type or print) DEATH 6 mmm 9. AGE (In years IF JNDER YEAR SEX DATE OF BIRTH 6. COLOR OR RACE 7. MARRIED NEVER MARRIED remave lost birthdoy) Months è Dovs dny DIVORCED WIDOWED 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT JSUAL OCCUPATION (Give kind of work done 11 BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) INDUSTRY **COUNTRY?** pleose Homemaker LLSA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 5.5. ma WAS DECEASED EVER IN J.S. ARMED FORCES? 36. SOCIAL SECURITY NO 17. INFORMANT Address (Yes, no, or unknown) ((If yes give wor or dotes of service) crematian, INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c),) ONSET AND DEATH burial-transit PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) signed by DUE TO Conditions, if any, which gove rise to immediate couse (a). DUE TO stating the underlying couse O FUNERAL DIRECTOR: After this certificate has been as the Health priar ta WAS AUTOPSY PERFORMED? PART U. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE LONDITION GIVEN IN use NO the haspital ar far 200 ACCIDENT WAS JNDERLYING [] 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) detached TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) factory, street, office bldg. etc.) Not While at work of work Page 4 may be retained by pe 21. I certify that (I) (this hostical) aftended the deceased from 6 M. Tram causes and an the date stated above and that death accurred at saw the deceased alive on 22o. SIGNATURE 22b. DATE SIGNED PHYS DIRECTOR M.D. director, page should be filed 22d. ADDRESS PHYSICIAN'S NAME (Type) 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (Stote) 230 BURIAL, CREMATION, 23b. DATE THEREOF (County) REMOVAL (Specify) Washington, D. C. Israel Cemetery 1967 Adas 25b. REGISTRAR'S SIGNATURE 250. REC'D BY REGISTRAR Stein Hebrew Memoria DDRESS 232 Carroll VR A15 (4) 20 M 1/66 Funeral Home Washington,



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12553 CERTIFICATE OF DEATH The low requires that the death certificate be executed within 24 hours after death 2. USUAL RESIDENCE (Where deceased lived, f institution. Residence before admission) PLACE OF DEATH b COUNTY Prince Georges o COUNTY Maryland Montgomerv MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 16 c (ITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) 47 Days Laurel Bethesda d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? 45 South Paula Street The Clinical Center, Bethesda, Maryland YES NO X 3. NAME OF DECEASED (Type or print) completely f 4. DATE OF DEATH Charles Blv September Edward NEVER MARRIED [X] B. DATE OF BIRTH S SEX 6 COLOR OR RACE 9. AGE (In years IF UNDER 1 YEAR 7 MARRIED [ Months DIVORCED | WIDOWED 20 February 195B White Male 10o USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR +2 CIT ZEN OF WHAT COUNTRY? 11 BIRTHPLACE (County & Stote, or foreign country). during most of working life, even if retired)
Student **INDUSTRY** USA Washington, D.C. 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME Curtis A. Blv Katherine Souder IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT The Medical Records (Yes, no, or unknown) (If yes give wor or dates of service) None The Clinical Center, Bethesda, Maryland IB. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I DEATH WAS CAUSED BY INTERVAL BETWEEN 3 WEEKS IMMEDIATE CAUSE (6) Respiratory Failure DUE TO Conditions, if ony, which gove ) (b) Pleural Effusion 1 month rise to immediate couse (a), DUE TO stoting the underlying couse ( Hodgkin's Disease vear PART IF OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES X NO Anemia: Herpes Zoster 200 ACCIDENT WAS JNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Port II of item IB) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c TIME OF INJURY Month, Day, Year 20e PLACE OF INJURY (Home, form, (City or town) (Stote) 20d INJURY OCCURRED (Coupty) foctory, street, office bldg . etc.) Not While 21. I certify that M) (this haspital) attended the deceased from 17 July , 19 67 to 2 Sept. , 1967, that M) (we) lost TO FUNERAL DIRECTOR: A director, page 3 should should be filed with the saw the deceased alive an 2 Sept. \_\_19\_67, and that death accurred at 8:55 M, from causes and on the date stated above 220 SIGNATURE ( 27b DATE SIGNED ATENDING DIRECTOR PHYS VI2 September 1967, 22d ADDRESS The Clinical Center, National M.D. 22c PHYSICIAN S NAME (Type) Robert C. Young, M.D. Institutes of Health, Bethesda, Md, 230. BURIAL, CREMATION, 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (Stote) REMOVAL (Specify) Cedar Hill Suitland 250 REG STRAR'S SIGNATURE 250 RECD BY REGISTRAR VR A15 (4) 25M 1/67 americo Pumphrey Inc. 8434 Ga. Ave. S.S. Md.



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item #7 Film #3393 9223237 ph CERTIFICATE OF DEATH 12563 requires that the death certificate be executed within 24 hours after death the funeral and PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. COUNTY a. STATE b COUNTY thin 7 hours offer d Montgomery MARYI AND Pennsylvania Wayne b CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) C LENGTH OF STAY IN 16 c CITY OR TOWN (If outside carporote limits, write RURAL and give necrest tawn) Waymart Bethesda 8 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS ON A FARM? filled Box 16 within. NO 30 The Clinical Center, Bethesda YES Maryland 3 NAME OF 4 DATE Last Manth Day Year теточе сагра DECEASED Gordon Emory Bond September DEATH 19 67 S SEX 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE B DATE OF BIRTH 7 MARRIED NEVER MARRIED lost birthday) Haurs DIVORCED / XI August 12, 1908 Male White WIDOWED 10a JSUALOCCUPATION (Give kind of work done during most of working life, even if retired)
GLAID: REULISA 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT attending physician opermit. Then please INDUSTRY COUNTRY? Pennsylvania 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME signed by the attending physichurial-transit permit. Then phen phenrial, cremation, or removal, Myron Bond Edith Emory WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT The Medical Records 20014 (Yes, no, ar unknawn) (If yes give war ar dates af service) 211-12-1035 The Clinical Center, Bethesda, Maryland IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Preumonia. INTERVAL BETWEEN ONSET AND DEATH DUE TO (b) Bone Marrow Aplasia Conditions, if any, which gave 3 10 days rise to immediate cause (a), DUE TO stating the underlying cause has been (d) Macroglobulinemic Lymphoma 4 years WAS AUTOPSY PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g) PERFORMED? YES X NO TO FUNERAL DIRECTOR: After this certificate 20a ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Manth, Day, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Harne, form, (City or town) (Caunty) (State) Hour am factory, street, affice bldg, etc.) Nat While of work at wark 21. 1 certify that (A) (this haspital) attended the deceased fram September 121967, to September 1967, that (A) (we) last saw the deceased alive an September 201967, and that death accurred at 2:30 M, fram causes and an the date stated above TO HOSPITAL OR ATTEND Poge 4 moy be retained 22a SIGNATURE 22b DATE SIGNED 20 Sept. 1967 PHYS DIRECTOR 22c - THY SICIAN 22d ADDRESS The Clinical Center, National NAME (Type) Donald N. Institutes of Health, Bethesda, Md Buell. BURIAL CREMATION 23b DATE THEREOF (State) BEMOVAL (Spyrify) 1567 Sanon Joursh 250 REC'D BY REGISTRAR 2Sb REGISTRAR SAIGNATURE FUNERAL DIRECTOR VR A15 (4) 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12555 12564 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. COUNTY o. STATE MARYLAND b CITY OR TOWN (If outside corporate limits C LENGTH OF STAY IN 16 c. CITY DR IDWN outside corporate limits, write RURAL and give regrest town filled in by the papers. Page hin 72 haurs o and give pencest town d NAME OF HOSP TAL OR INSTITUTION (If not in hospito), give street address? d STREET ADDRESS IS RESIDENCE ON A FARM? YES NAME OF Middle DATE coproferely solve corbon First Lost Dov Year DECEASED OF (Type or point) DEATH S. SEX AGE (In years lost birthday) IF JNDER IF UNDER 24 HRS 6 COLOR OR RACE DATE OF BIRTH 1 YEAR 7 MARRIED **NEVER MARRIED** Months Dovs Hours WIDOWED DIVORCED guq 100 JSUAL OCCUPATION (Give kind of work done during most of work ag life even if retired) 10b, KIND OF BUSINESS OR 11 SIRTHPLACE (County & State, or foreign country) 12 CIT ZEN OF WHAT INDUSTRY COUNTRY? 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAMI remaval WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO INFORMANT Address (Yes, no or unknown) (If yes give wor or dates of service) 5 crematian, 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN ONSET AND DEATH PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) signed by DUE TO Conditions, if any, which gave rise to immediate couse (a). DUE TO stoting the underlying couse O HOSPITAL OR ATTENDING PHYSICIAN: The law re Page 4 may be retained by the baspital or attending as the has been priar to PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO WAS AUTOPSY PERFORMED? THE TERMINAL NO X YES F TO FUNERAL DIRECTOR: After this certificate 20o. ACCIDENT WAS JINDERLYING [7] 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port 1 of Port 1 of Item 18 OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL 20c. TIME OF ALJRY Month, Doy, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour 'o.m. factory, street, office bldg , etc } Not While at work ot work 21. I certify that (1) (this haspital) attended the deceased from 196 , that (I) (we) los and that death accurred at 130 M, from causes and an the date stated above saw the deceased alive on 220 SIGNATURE 22b. DATE SIGNED ATTENDING M.D PHYS DIRECTOR PHYS 22d ADDRESS 22c PHYSICIAN'S NAME (Type) 230 BURIAL, CREMATION 23b DATE THEREO NAME OF CEMETERY OR CREMATORY LOCATION (City or Town (Stote) (County) REMOVAL (Spec fly) REGISTRAR S SIGNATURE VR A15 (4) 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12556 12565 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death funeral 1 and PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) COUNTY UMERI MARYLAND by the 11. Pages CTY OF TOWN (If outside corporate limits, c LENGTH OF STAY IN 16 outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest fawn) nours papers. filled m d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) & STREET ADDRESS e IS RESIDENCE hin 72 ON A FARM? YES NO 🗷 DATE OF DEATH NAME OF Middle First Month Year remove-eatban DECEASED (Type or print) event. S SEX 6. COLOR IF UNDER 1 YEAR OR RACE AGE ( n years 7. MARRIED NEVER MARRIED act birthdov) Months Davs Hours WIDOWED DIVORCED July 29,1883 10o. LSUAL OCCUPATION (Give kind of work done KIND OF BUSINESS OR 11 BIRTHPLACE (County & Stote, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) U.S.Gov't. COUNTRY? 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ar remayal. Christine Elsenheimer Bernard Borlis IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT (Yes, no or unknown) (If yes give wor or dates of service) None Mrs. Tebbetts C. Borjes, Wife, Same burial, crematian, INTERVAL BETWEEN PASET AND DEATH 1B. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c)) burial-transit PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) signed by Page 4 may be retained by the haspital ar attending physician. DUE TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO stating the underlying couse O FUNERAL DIRECTOR: After this certificate has been the 19 WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) NO A ď 200 ACCIDENT WAS UNDERLYING [7] 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port 1) of item 1B i OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (Stote) (C ty or town) (County) factory, street, office bldg, etc.) Not While 21. I certify that (1) (this higsgitas), attended the deceased fram. , page 3 should be filed with the saw the deceased alive an and that death accurred fram causes and an the date stated above 220 SIGNATURE DATE SIGNED ATTENDING PHYS MED DIRECTOR STAFF M M.D. PHYSICIAN'S **ADDRESS** NAME (Type) directar, shauld b 230. BURIAL, CREMATION, Cremation 23b. DATE THEREO 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) Crematory Suitland VR A15 (4)



VR A15 (4) 15M 9/59

12557

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

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and the second s	
1. PLACE OF DEATH o. COUNTY  MONTGOMERY  MARY	2 USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) o. STATE b. COUNTY MARYLAND MONTGOMERY
b. CITY OR TOWN (If outside corporate limits, write   c. LENGTH OF STAY	
RURAL and give hearest town)  SICUER SPRING  16 4R5	
A NIANE OF WOODITAL III and as baseled away street address)	d, STREET ADDRESS 6. IS RESIDENCE
OR INSTITUTION  TIO SILVER SPRING, MD.	710 SILVER SPRING AVENUE YES NO E
DECEASED	OF
(Type or print) NORM AN HALE	BOWMAN DEATH SEPT, - 1967
S SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRI	ED B. DATE OF BIRTH  9. AGE (In years   IF UNDER 1 YEAR IF UNDER 24 HRS lost birthdoy)   Months   Days   Hours   Min.
MALE WHITE WIDOWED IT DIVORCE	
10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS C during most of working life, even if retired)	OR INDUSTRY 11 BIRTHPLACE (Stole or foreign country) 12. CITIZEN OF WHAT COUNTRY?
	ruction VIRGINIA U.S.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
SAMUEL BANKS BOWM	AN ELIZABETH DICKENS
15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO	
(Yes, no, or unknown) (If yes, give wor or dates of service, 7.17 09 / 364 A	MRF. TRUDA BARNES AS ABOVE
1B. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c)	INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (0) CANCER	OF URINARY BLADDER 8 4EARS
1010 DUE TO	
	OCAL METASTASIS
gove rise to immediate DUE TO	
lying couse lost. (c)	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DE	ATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED?
CATI	YES NO E
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DE  200. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	CCURRED. (Enter nature of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, form,   20f (City or town) (County) (State)
20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED While Not while of work of work	foctory, street, office bldg., etc.)
21. I certify that (1) (this haspital) attended the deceased	fram. 7/30 1959, ta SEPT. 2 , 1967, that(1)(we) last
saw the deceased alive an SEPT. 2 19.67 and	that death accurred at AM, from the causes and an the date stated above
220 SIGNATURE	22b DATE
James a. Koberts	M D PHYS DIRECTOR PHYS SEPT. 2, 196
22c PRYSICIAN'S NAME (Type) A R RECRET	22d ADDRESS
NAME (Type) TAMES A. ROBERTS	8907 GEORGIA AVE, SILVER SPRING, MD.
	ETERY OR CREMATORY 23d. LOCATION (City, fown, or county) (Stote)
REMOVAL (Specify) Sept. 6,1967 Hart Si	prince George County Md
24 FUNERA DIRECTOR'S STEPNATURE THAT ADDRESS	250 REC'D BY REGISTRAR 256 REGISTRAR'S SIGNATURE
Warner E. Pumphrey, Inc. 8434 Ga. Au	e S.S. Md DASEP 8 1967 Mclianley Yudge.
C. I vanjiveey, Mc. 1414 ya. 110	2. 2. 2. 110.

O LINE DEPARTMENT OF

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12558 2567 CERTIFICATE OF DEATH The low requires that the death certificate be executed within 24 hours after death 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission.) PLACE OF DEATH o. COUNTY b. COUNTY North Carolina Montgomery MARYLAND filled in by the poges popers. Pages hin 72 hours afte b CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) Camp LeJuene days Bethesda (rural IS RESIDENCE ON A FARM? d. NAME OF HOSP TALL OR INSTITUT ON (If not in hospital, give street oddress) d. STREET ADDRESS MOQ 2102 MCB NO X Naval Hospital Doy 4 DATE Month confipletely had confident 3. NAME OF First Year buriol, cremation, or removol, and in any event, w DECEASED OF DEATH September 67 BRAY William Terrill 19 (Type or print) IF UNDER 24 HRS. DATE OF BIRTH AGE (In years S SEX 6. COLOR OR RACE 7 MARRIED NEVER MARRIED birthday) Manths Haurs Dec. 14, 1916 ottending physicion and co permit. Then please remov Male Cauc DIVORCED WIDOWED 12. CIT!ZEN OF WHAT 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 10a LSUAL OCCUPATION (Give kind of work done COUNTRY? USA during most of working life, even if retired)
U. S. Marine Corps INDUSTRY Oak Park, Illinois 13. FATHER S NAME 14 MOTHER'S MAIDEN NAME Louise Terrill William John Bray Camp LeJuene. Newth Carolina 17. INFORMANT IS WAS DECEASED EVER IN U.S ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes on arunknawn) (If yes give war ar dates of service) signed by the ottendii buriol-tronsit permit. Mrs. Harriet Bray, MOQ 2102, MCB 348 01 0974 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) Lymphatic
PART I. DEATH WAS CAUSED BY Chronic hymphatic/Leukemia with bilateral INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (o) Poge 4 may be retained by the hospital or attending physician. bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate couse (a), DUE TO stating the underlying cause this certificate hos been for use as the PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) WAS AUTOPSY PERFORMED? TO FUNERAL DIRECTOR: After this certificate ho director, page 3 should be detached for use should be filed with the State Dept. of Health | YES XX NO [ 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Part I or Part II of Item 18.) 20g ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20e. PLACE OF INJURY (Hame, form, (City or lown) (County) (State) 20d INJURY OCCURRED 20c. TIME OF INJURY Month, Day, Year factory, street, affice bldg., etc.) Hour a.m. Not While 21. I certify that (I) (this haspital) attended the deceased from Sept. 21 , 1967, to Sept. 28, 1967, that A (we) last 19 67, and that death occurred at 655P M, from causes and an the date stated above saw the deceased alive an Sent 28 220. SIGNATURE 22b. DATE SIGNED STAFF PHYS **ATTENDING** Sept. 29, 1967 DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S MAME (Type) Daivd R. Foreman, M. D. Naval Hospital, Bethesda, Maryland 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State) 23b DATE THEREOF 23a BUR AL CREMATION, BEMOVAL (Specify) 10/3/67 Arlington, Virginia Arlington National 24. FUNERAL DIRECTOR FellsChurch Funeral Afterne W. J. M. Chiloso-FECD BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE YR A15 (4) 20 M 1/66 1102 West Broad Street, Falls Church, Va.



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12568 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission b. COUNTY Montgomery a. COUNTY Montgomery MARYLAND b CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town) LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAt and give nearest town) hours Silver Spring O HOSPITAL OR ATTENDING PHYSICIAM: The low requires that the death certificate be executed within 24 hours Olney d. STREET ADDRESS d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) e IS RESIDENCE ON A FARM? Montgomery County General Hospital 9020 Fairfield Road YES NO [33] NAME OF Middle corbon 4 DATE 1ost Year Day DECEASED (Type or print) OF DEATH Sept. 11. 1967 HANNAH BROOME MARY IF JNDER 1 YEAR | I IF UNDER 24 HRS 6 COLOR OR RACE 7 MARRIED B DATE OF BIRTH 9 AGE (In years NEVER MARRIED remove last birthacy) May 5, 1886 White and in any Comale WIDOWED DIVORCED puo 100 USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT physicion a ien please during most of working the even if retired) INDUSTRY COUNTRY? Camden. Ohio S. 13 FATHER 5 NAME 14. MOTHER S MAIDEN NAME buriol, cremation, or removol, Dr.Charles C. Lillie Moreatt Jones 17. INFORMANT 15 WAS DECEASED EVER IN U.S. ARMED FORCES? Daughter 16 SOCIAL SECURITY NO Address (Yes, na, or unknown) (If yes give war or dates of service Eleanor Broome 20-44-1448 INTERVAL BETWEEN 18 CAUSE OF DEATH (Enter only one couse per time fer (o), (b), and (c)
PART I DEATH WAS CAUSED BY has been signed by the se as the buriol-tronsit ONSET AND DEATH IMMEDIATE CAUSE (o) Page 4 may be retained by the hospital or ottending physicion. **DUE TO** Canditrans, if any, which gove rise to immediate couse (a). DUE TO stating the underlying couse lost. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? Stote Dept. of Health NO DE 200 ACCIDENT WAS JNDERLYING 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Port II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER (City or town) 20c TIME OF INJURY Manth, Dov. Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, form, (County) (State) Hour To.m. factory, street, affice blda., etc.) Not While O FUNERAL DIRECTOR: After 21 | certify that (1) (this massifel) attended the deceased fram March 19**67**, that (I) (<del>we)</del>-last 1967, and that death accurred at 650 M, from causes and an the date stated above saw the deceased alive an 220 SIGNATUR 226 DATES GNED director, page 3 should be filed v M.D DIRECTOR 22d ADDRESS PHYS CIAN S N. VanBuren NAME (Type) ARTHUR F. WOODWARD Rockville. Maryland 23c NAME OF CEMETERY OR CREMATORY 230 BUR AL, CREMATION 23b. DATE THEREOF 23d .OCATION (City or Town) (County) (State) REMOVAL (Specify) 9-13-67 Darnestown Fresby, Cem. Darnestown, maryland uria 24. FUNERAL DIRECTOR 25b REGISTRAR'S SIGNATUR 25a. REC'D BY REGISTRAR **ADDRESS** PUMPHRFY, Bethesda, Maryland



## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH

	(IVI)		12560 CERTIFICATE OF DEATH	569
eath	the funeral ages I and is after death	1	PLACE OF DEATH # 2 USUAL RESIDENCE (Where decreased lived if institution Residence before	re odmission)
P ia	fund 1 c		o. COUNTY Montgomery MARYLAND o. STATE Maryland b. COUNTY Nortego	mery
<del>f</del>	the ages s aft		UTIT DK IDWN (IT Outside corporate limits, write RURAL and give neores truen)  C LENGTH OF STAT IN 16  C CITY OR TOWN (IT outside corporate limits, write RURAL and give neores truen)	town)
Surs	<b>7</b> 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		Garrett Park   years   Garrett Park	15
4 4	E se E	1	, , , , , , , , , , , , , , , , , , , ,	B IS RESIDENCE DN A FARM?
II 2		-		YES NO IX
d with	- Sagar		NAME OF PECEASED THOMAS DROWN Lost 4 DATE OF Sept. 21,	39 67
that the death certificate be executed within 24 haurs after death an.	and completely filled in by the fremave carbon papers. Pages n any event with, a 2 hours after	_	SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED B DATE OF BIRTH 9. AGE (In years lost birthday) Acres Widowed Divorced Sept. 4, 1907 60 yrs	Hours Min
te be 6	attending physician and co vermit. Then please rema an, ar remaval, and in any	dug	Do JSUAL OCCUPATION (Give kind of work done upge most of working life, even if refired)  LOO DO JSUAL OCCUPATION (Give kind of work done upge most of working life, even if refired)  LOO DO JSUAL OCCUPATION (Give kind of work done upge most of working life, even if refired)  LOO DO JSUAL OCCUPATION (Give kind of work done upge most of working life, even if refired)  LOO DO JSUAL OCCUPATION (Give kind of work done upge most of working life, even if refired)  LOO DO JSUAL OCCUPATION (Give kind of work done upge most of working life, even if refired)  LOO DO JSUAL OCCUPATION (Give kind of work done upge most of working life, even if refired)  LOO DO JSUAL OCCUPATION (Give kind of work done upge most of working life, even if refired)  LOO DO JSUAL OCCUPATION (Give kind of work done upge most of working life, even if refired)  LOO DO JSUAL OCCUPATION (Give kind of work done upge most of working life, even if refired)  LOO DO JSUAL OCCUPATION (Give kind of work done upge most of working life, even if refired)  LOO DO JSUAL OCCUPATION (Give kind of work done upge most of working life, even if refired)  LOO DO JSUAL OCCUPATION (Give kind of work done upge most of working life, even if refired)  LOO DO JSUAL OCCUPATION (Give kind of work done upge most of working life, even if refired)  LOO DO JSUAL OCCUPATION (Give kind of work done upge most of working life, even if refired)  LOO DO JSUAL OCCUPATION (Give kind of work done upge most of working life, even if refired)	
ifica	al, o	13.	3. FATHER'S NAME 14. MOTHER'S MAIDEN NAME	
cert	ling physical Then properties of the properties		Albert Brown Rosina Franz	
ath	endin nit. T ar res		S WAS DECEASED EVER IN US ARMED FORCES?  Yes, no, or unknown) (II yes give wor or dates of service)  215-26-0659 Ann B. Frown  Said to Ito	1
e de	attendu permit. Ian, ar re		110	
nat the	the start promoter			ERVAL BETWEEN
requires fl	signed by the burial-transit burial, cremat		Conditions, if ony, which gove (b) (b) Artice de to Heart Acres (c)	litim
The taw requires the ottending physician.	as been single by the prior to bu		stoting the underlying couse (c) DUE TO (c)	
		ATION	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  19 Y	WAS AUTOPSY PERFORMED? TES NO TO
PHYSICIAN:	作るも	CERTIFICATION	20c ACCIDENT WAS UNDERLYING  20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
_	this detac ie Dep	MEDICAL	20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, Hour o.m. 4 While at work at work at work 19 At work 1	(State)
ATTENDING	After d be e Stal		2). I certify that (1) (this hospital) extended the deceased from 3-26, 1963, to-ket 1, 1961, the	iat (1) (we) last
TEN IN BE	<b>9</b> 8 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5		saw the deceased alive an 1967, and that death accurred at 196 M, fram causes and on the dat	
OR Al	DIRECTO ge 3 sho led with		220 SIGNATURE  M.D. ATTENDING  MED  STAFF  9-21-0	
O HOSPITAL OR ATTENI	director, page should be filed		NAME (Type) GEORGE SHARPE 22d ADDRESS 10400 Country lan	3
HOS	o FUNER director, should be	234	30 BURIAL, CREMATION, 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County	, ,
00	5-44W		Burial 9-23-67 Gate of Heaven Cem. Silver Spring, in	ryland
V	R A15 (4)	Ŕ	24 EUNERA DIRECTOR PUMEHRLY, Bethesda, Maryland DATE SEP 25 1967	42



O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

completely 50

puo

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and director, page 3 should be detached for use as the buriol-transit permit. Then please rem should be filed with the State Dept. of Health prior to buriol, cremation, or removal, and in an

Page 4 may be retained by the hospital or attending physician.

VR A15 (4) 25M 1/67

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12570

	,	o. COUNTY Montgomery	MARYLAND	o State Maryland Montgomery			
	ŀ	b CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town)	c LENGTH OF STAY IN 116	c CITY OR TOWN (If outs)	de corporote limits, write RURA.	ond give neorest town)	
		Silver Spring		Rockville		15 /	
,		d NAME OF HOSPITAL OR INSTITUTION (If not in hospital	il, give street oddress)	d. STREET ADDRESS		e IS RESIDENCE ON A FARM?	
		Holy Cross Hospital		4434 Hallet	Street	YES NO 🔀	
	-	NAME OF First DECEASED STACEY (Type or pnnt)	Middle SUE B'RRANK	Lost	4 DATE Month OF September DEATH	/3 Year	
	5 :	SEX 6. COLOR OR RACE 7 MARRIE	D NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years	FUNDER 1 YEAR   IF UNDER 24 HRS.	
		'emale White WIDOWE		19-7-:	Yrs	Months Days Hours Min	
	10o duri	USUA, OCCUPATION (Give kind of work done ing.most.of.working life, even if retired)	KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & S	tate, or foreign country)	12 CITIZEN OF WHAT	
	13.	FATHER S NAME		14. MOTHER'S MAIDEN NA	WE		
		Perry F. Burbank	TTT	Susan Ro	hant		
	S			INFORMANT	Address		
	(Ye			T	- Poths		
	7	18. CAUSE OF DEATH (Enter only one couse per line		rry F. Burb	ank III Fathe	r- same item 2	
		PART I. DEATH WAS CAUSED BY		ant Parilie	0 1 1 1 1	ONSET AND DEATH	
		197. L IMMEDIATE CAUSE (o)	ingestive h	Ewel Jumair	2 110		
1		Canada and State and Albania a	Day O as you or her	insufficie		month	
	- 1	(0)			1		
1		stating the underlying couse DUE TO	malignant	tonata	1//	1 year	
		(0)	4	7	M. W. S.	In war a Topey	
	Ñ.	PART 1. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING	G TO DEATH BUT NOT RELATED TO	THE TERMINAL DISEASE CONDI	ON GIVEN IN PART 1(0)	19 WAS AUTOPSY PERFORMED?	
	3	no. According was appreciated in	DECEMBER WALL WHITE ACCURATE	trata and an all and a Dr	a i D a i i ( b 16 )	YES NO	
	L CERTIFICATION	206 ACCIDENT WAS JNDERLYING  OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	DESCRIBE HOW INJURY OCCURRED	(Erner notate of infirity in Fol	I FOR PORT II OF FEM 10 )		
	MEDICAL			CE OF INJRY (Home, form,	20f (City or town)	(County) (State)	
	岁	1100	rock O of work O	lory, street, office bldg , etc.)			
		21 I certify that (1) (this haspital) atte		JUNE 191	07 10 Sept 12	, 1967, that (I) (we) last	
		saw the deceased alive an sept	, /2 19 67, and tha	t death accurred at 9.	30P M, fram causes an	d an the date stated above	
		22o. SIGNATURE	A >=	ATTCHBUNG . A MI	FD 57455	22b DATE SIGNED	
		Coderaid	& tecoli M		ED STAFF RECTOR PHYS	9/14/6/	
ı		22c PHYSICIANS NAME (Type) Edward Ferol	i	22d ADDRESS 213 N. Fred	erick Ave., Cai	ithersburg.Nd.	
1						·	
	230	BURIAL, CREMATION, 23b. DATE THEREOF	23c NAME OF CEMETERY OR	CREMATORY	23d LOCATION (City or Town)	, , , , , ,	
		Burial 9/16/67	Parklawn		Rockville,		
	24	. FUNERAL DIRECTOR Tyson Wheeler Funeral F	Home 1331 Rock	Pike 250. RECD	F T 8 1987 1987	DARS SIGNATURE MARGE	



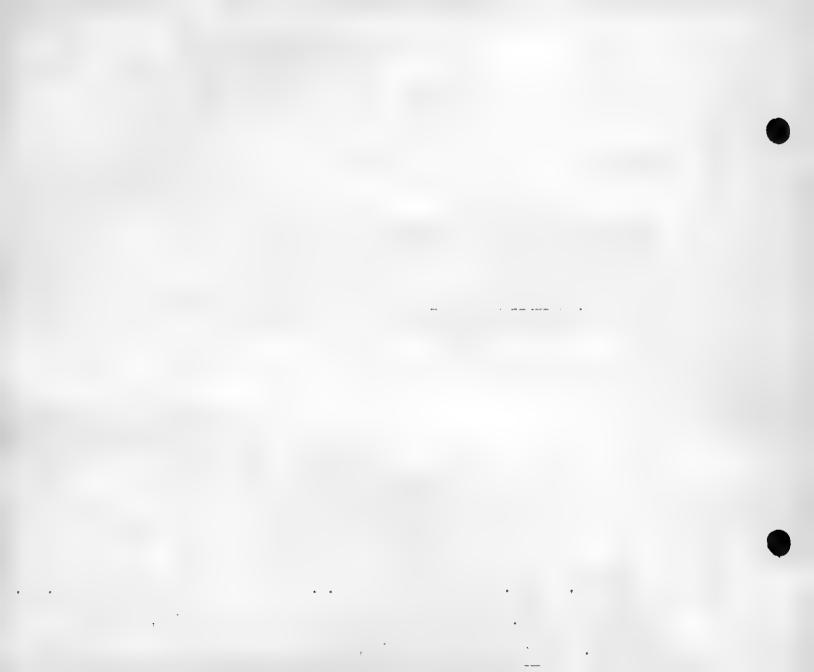


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12563 12572CERTIFICATE OF DEATH Rea. Dist. No. eral director, be filed with PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. COUNTY b. COUNTY Montgomery MARYLAND Maruland CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) Silver Spring Ayattsville 4 years d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS a. IS RESIDENCE ON A FARM? thea Woodland Nursing Home 1000 Dalewsew Dr. 7002 Lovell Drive YES TO NO TO NAME OF DECEASED 4. DATE Month filled Sthol DEATH (Type or print) Burton Sentember 19 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 1 8. DATE OF BIRTH completely 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS Female WIDOWED A DIVORCED [7] 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired)
Ketired Owner Florist & Nurseries Baltimore. Maruland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME William J. Gesstord 2da Shepperson 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMANT Address 7002 Lovell Dr. Hyattsu Nο 214-32-8226 Burton 18. CAUSE OF DEATH [Enter only one couse per ling for (a), (b), and (c). INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (c) **DUE TO** Canditions if ony, which gned (b) gave rise to immediate DUE TO cause (o), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONFRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL PERFORMED? YES NO IN 200 ACCIDENT WAS UNDERLYING [ 20b DESCRISE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18) OR CONTRIBUTING | CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) Month, Doy, Year 20d INJURY OCCURRED (County) (Stote) foctory, street, office bldg., etc.) Hour o.m. While Not while at wark at work p. m. 21. I certify that I attended the deceased from that I last saw the deceased alive an and that death accurred at Co. P. M. from the causes and an the date stated above. SIGNATURE noy be retained FUNERAL DIR. page 3 should be PHYSICIAN'S NAME (Type) 22b DATE THEREOF 220. BURIAL, CREMATION. 22d. LOCATION (City, town, or county) 22c. NAME OF CEMETERY OR CREMATORY (State) REMOVAL (Specify) 240 RECID BY REGISTRAR 246. REGISTRAR'S SIGNATURE Georgia Ave -15M 9/58



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12573 12564 CERTIFICATE OF DEATH PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death the funeral PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) o. COUNTY MARYLAND b. CITY OR TOWN (If autside carparate limits, c LENGTH OF STAY IN 16 CEITY OR TOWN (IF autside corparate limits, write RURAL and give aearest town? write RURAL and give nearest town) d. STREET ADDRESS e IS RESIDENCE ON A FARM? d NAME OF HOSPITALOR INSTITUTION (If not in haspital, give street address) campletely filled in nove carbap-paper Hospital 듣 NAME OF Middle First Last 4. DATE DECEASED (Type ar pant) S SEX NEVER MARRIED AGE (in years 7 MARRIED lost birthday) Manths Days WIDOWED DIVORCED INDUSTRY ACCT. Off 100 USUAL OCCUPATION (Give kind of work done 12. C TIZEN OF WHAT physician c during most of virarking/life, even if retired) lanager 13. FATHER'S MAME 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT (Yes, go of unknown) (If yes give war : , dot Frervice) None Same as Item 2. John P. Callanan crematian, CAUSE OF DEATH (Enter only and cause per line for (a), (b), and (c)) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY: this certificate has been signed by DUE TO Conditions, if any, which gave 3 (b) rise to immediate couse (o), DUE TO stating the underlying couse far use as the Health priar to PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19 WAS AUTOPSY PERFORMED? NO -20g ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Port II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (City or town) (County) (State) factory, street, affice bldg, etc.) Nat While 21/) certify that (I) (this haspital) attended the deceased from 3/2 1927 that (i) (we) last land that death accurred at 31.44M, from causes and on the date stated above saw the deceased alive an 120/ SIGNATURE DATE SIGNEDY M.D. 22d ADDRESS Bradlev 22c. PHYSICIAN'S NAME (Type) Dathesda. 30 BURIAL, CREMATION, REMOVAL (1906) 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) 9-26-67 St. John's Cemetery Forest Glen, maryland 24. FUNERAL DIRECTOR PUMPHRFY. Pethesda. Maryland DATE



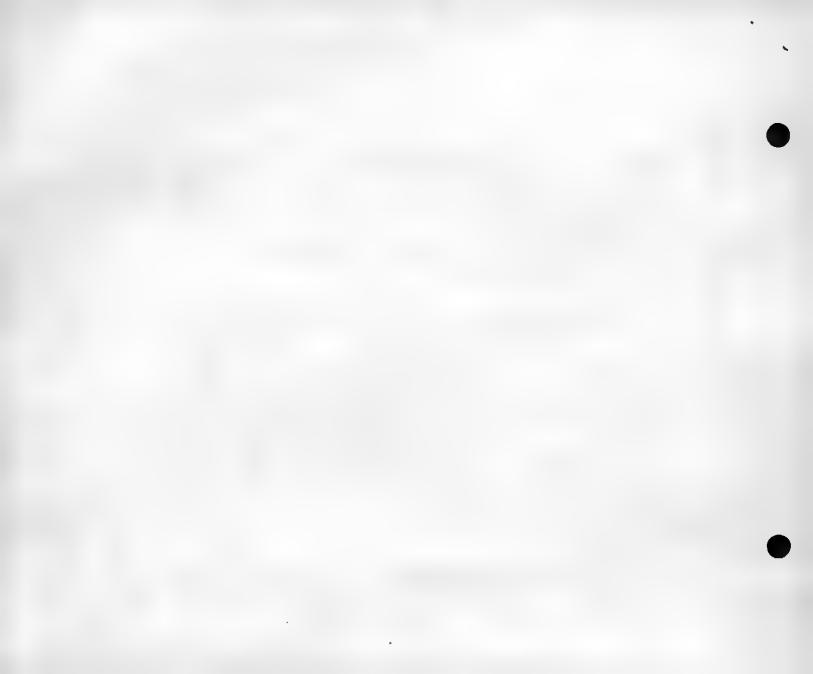


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1 \~	ľ	DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	1 n p M p
2 2 - 1		12565 Item #2d Film #G CERTIFICATE OF DEATH	101
death death		LACE OF DEATH  COUNTY  MARYLAND  2 USUAL RESIDENCE (Where deceased lived, of institution of STANG.  D. MOYT	Residence before admission)
haurs after n by the for s Pages haurs after		CITY OR TOWN (If outside corporate limits, C. LENGTH OF STAY IN 15 ) CITY OR TOWN (If outside corporate limits, write RURA	L and give nearest fown)
by the Parts and S		Silver Spring	
4 ho		NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address)  d. STREET ADDRESS 218 Shaw Ave	e is res dence on a farm?
within 2	13	TAME OF First Middle Last 4 DATE Month	Day Year
campletely filled in tave carbon papers by every within 22 h	A 1	IAME OF First Middle Last 4 DATE Month light OF DEATH SEFT.	10, 1967
npte e ca	S	EX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 8 BATE OF BIRTH 9. AGE (INVAORS	IF UNDER 1 YEAR   IF UNDER 24 HRS
e execute and cami remave	L	What WIDOWED DIVORCED Sept. 13, 1888 losty8thdoy)	
be ex and e rem	10a	USUAL OCCUPATION (Give kind of work dane 10b KIND OF BUSINESS OR 11 BIRTHPLACE (Caunty & State, ar foreign country) INDUSTRY	12 CITIZEN OF WHAT COUNTRY?
afe ician leas		Housewife at home Maryland FATHER'S NAME 14. MOTHER'S MANDEN NAME	U-S-A-
rtific phys en p	13.	Samuel T. Addison Mary Elizabeth Micou	
ing ing	15	WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT Address	Lestings.
deat tend mit.	(¥ e	i, no, or unknown) (If yes give wor or dates of service) Mr. Addison Cempbell 1740-16	and Ave N. 4'-
quires that the death certificate be executed physician. signed by the attending physician and cample! burral-transit permit. Then please remaye carbural, crematian, ar removal, and in any event		18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY.	INTERVAL DETWEEN ONSET AND DEATH
that in. by th ansi		IMMEDIATE CAUSE (a)	
equires that the physician. signed by the burial-transit burial, cremat	Ш	Conditions, if any, which gove ) (b) Cona He and Failure	2-34cars
sign bur		rise to immediate couse (a), stating the underlying cause DUE TO	
aw r ding ding ding arte		lost. (1) Mitrol Stanosts	58 yacro.
TO HOSPITAL OR ATTENDING PHYSICIAN: The aw requires the Page 4 may be retained by the haspital ar attending physician.  TO FUNERAL LIRECTOR: After this certificate has been signed by director, page 3 should be detached far use as the burial-transhauld be filed with the State Dept. af Health priar ta burial, cre	CERTIF.CATION	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	19 WAS AUTOPSY PERFORMED? YES NO
tal of ficat far	RTFE.C	20a ACCIDENT WAS UNDERLYING	
vsic certical	AL CE	(IF EITHER, NOTIFY MEDICAL EXAMINER)	(County) (State)
DING PHYS by the has fifer this cer be detache State Dept.	MED.CAL	20c TME OF NJURY Manth, Day, Year Haur a.m. p.m. 19 20d INJURY OCCURRED While Not While at work of wor	(51014)
d by After d be 5 Stat		21. I certify that (1) (this hospital) attended the deceased from 10 - 2	, 19 <u>.6.7,</u> that (I) ( <del>wo)</del> las
OR: TEN		saw the deceased alive an 9-9 1967, and that death accurred at 650 AM, from causes a	nd an the date stated above 22b. DATE SIGNED
RECT 3 st dwith		M.D. ATTENDING MED STAFF DIRECTOR PHYS D	9-10-67
AL O Ny be L III		22c PHYSICIANS P. H. S. J.C. 1	1 - 1 - 1
SPIT. 4 mg IERA or, p			a Kema Pont, Md
TO HOSPITAL OR ATTENE Page 4 may be retained TO FUNERAL BIRECTOR: A director, page 3 should should be filed with the	230	BUR AL CREMATION, 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town	, , , , , , , , , , , , , , , , , , , ,
		FUNERAL DIRECTOR  ADDRESS  250 REC'D BY REGISTRAR  250 REC'D BY REGISTRAR  250 REC'D BY REGISTRAR  250 REC'D BY REGISTRAR	ISTRAR S SIGNATURE
VR A15 (4) 25M 1/67		William & Dickney & Sons Months Padres DASEP 15 1967 Jo	liarles Judges



MARYLAND STATE DEPARTMENT OF HEALTH 1256 a DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12576 CERTIFICATE OF DEATH O HOSPITAL OR ATTENDING PHYSICIAN: The taw requires that the death certificate be executed within 24 haurs after death. camplekely filled in by the funeral ove carbon-rappies. Pages 1 and 2 y event with n /2 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) p. COUNTY a. STATE b. COUNTY Montgomery MARYLAND Pennsylvania b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 15 50 days Bethesda Hellam d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) IS RESIDENCE ON A FARM? d. STREET ADDRESS YES NO IX The Clinical Center, Bethesda, Maryland R.D. #1 3. NAME OF Last 4. DATE Manth Oay Year DECEASED (Type or print) OF DEATH September Christine Carbaugh Marie the attending physician and cample) sit permit. Then please remave car burial, crematian, ar remaval, and in any event IF UNDER 24 HRS SEX 6. COLOR OR RACE B. DATE OF BIRTH 9 AGE (In years IF UNDER I YEAR 7. MARRIEO NEVER MARRIEO Months last birthday) Hours White 14 May 1961 Female WIGOWEO DIVORCEO 10a USJAL OCCUPATION (Give kind of work dane during most of working life, even if retired)
Child 10b. KINO OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT INDUSTRY COUNTRY? Pennsylvania USA None 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME John Carbaugh JoAnn Van Valkenburgh 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT The Medical Recorddress 16 SOCIAL SECURITY NO (Yes, no, ar unknown) (If yes give war ar dates of service) The Clinical Center, Bethesda, Maryland None IB. CAUSE OF DEATH (Enter only one cause per inne for (a), (b), and (c))
PART I. CEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
Respiratory INTERVAL BETWEEN signed by the bur al-transit p 50NH LANGUEUE Respiratory Arrest Page 4 may be retained by the haspital ar attending physician. 204,0 **QUE TO** Multiple Microabcesses Conditions, if any, which gave 1 2 weeks rise to immediate cause (a), DUE TO stating the underlying cause (c) Acute Lymphocytic Leukemia 3 years has PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS ALTOPSY PERFORMEO? CERTIFICATION YES X NO 205 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 11 of item 18.) 20g ACC DENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Oay, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, form (City or town) (County) (State) O FUNERAL DIRECTOR: After this Hour a m. factory, street, affice bldg. etc.) Nat While at work at wark 21. I certify that (1) (this haspital) attended the deceased fram 9 August, 1967, to 28 Sept., 1967, that (2) (we) last saw the deceased alive an 28 Sept. 1967, and that death accurred at 9:55 M. fram causes and an the date stated above. 22a SIGNATURE 22b. DATE SIGNED ATTENDING STAFF PHYS 29 Sept. 1967 M.O **OIRECTOR** 22d ADDRESS The Clinical Center, National PHYSICIAN S NAME (Type) Robert Young, MD Institutes of Health, Bethesda, Maryland 23d LOCATION (City or Town) 23b, DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23a BURIAL, CREMATION, (State) Burlal (Specify) 10-2-67 Laurel Hill Cem. Columbia, Penna. 2Sb REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR PUMPHRY, Bethesda, Maryland 2Sq REC'D BY REGISTRAR 1967 Ithanker Judge

VR A15 (4) 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12577 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE 12568 HEALTH & DEPT I. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) o. COUNTY o STATE b CDUNTY Poge 11070 MARYLAND b CITY OR TOWN (It outside corparate CLENGTH DE STAY IN 1b. CLITY DR TDWN ( f autside comparate mits write RURA; and give mortest town) puo PM3. write RURAL and a ve nearest town) State Departm d NAME OF HOSPITAL OR INSTITUTION (If negan haspital, give street address) e. IS RESIDENCE Office along with farm ON A FARM? in Item 18. Give Poges 1, 110- FIDDLERLAMS YES ND be executed within 24 hours after death NAME OF Middle DATE First Last Doy Year DECEASED OF DEATH (Type or print) Wauman armichael. 19 AGE 6 COLOR OR RACE 7 MARRIED NEVER MARRIED DATE OF BRITH (In years dost 46 birthdoy) Months Dovs Sept. 10. 1920 WIDOWED DIVORCED 72 hours ofter deat 10a USUA, OCCUPATION (Give kind of work dane 106 KIND DF BUSINESS OR 11 BiRTHPLACE (State or fare an country) 12 CITIZEN OF WHAT during mast of warking life, even irretired on such and in irretired Oklahoma Navy Dept. nding' in pencil in Medical Examiner's 13 FATHER'S NAME 14 MDTHER'S MAIDEN NAME George E. Carmichael Hazel Wayman 17 INFORMANT 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY ND. (Yes, na, ar unknawn) (If yes give war ar dates af service event within Mrs. "anet M. (armichael Silver Spring 18 CAUSE OF DEATH (Enter only one cause per one for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY buriol-transit IMMEDIATE CAUSE (a) certificate should DUE TO in ony Conditions, if ony, which gave rise to immediate cause (a), forwarded to DUE TO stating the underlying cause last. 19 WAS AUTOPSY PERFORMED? removol, PART II DTHER'S GNIFICANT COMO TIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(g) ND. þe 20g. EXTERNAL CAUSE WAS 20b DESCRIBE HDW INJURY OCCURRED (Enter nature of injury in Part I or Part I of Item 18) 3 should 07 PRIMARY I or CONTRIBUTING I 4 should CAUSE DE DEATH cremotion, 20c TIME OF INJURY Month, Day, Year 20d INJURY DCCURRED 20e PLACE OF NJURY (Home farm, 20f (City or town) (Caunty) (Stote) Not While Haur a.m. foctory, street office bldg etc.) FUNERAL DIRECTOR: Page at work 21. I certify that I taak charge of the remains described above, held an Autapsy and in my apinian Inspect an Inquiry Natural causes Accident Suicide [ Hamicide Undetermined manner funeral director. death resulted fram be retained CHIEF MEDICAL EXAMINER ACTUAL SIGNATURE 22. DATE SIGNED ASSISTANT MEDICAL EXAM NER prior O DEPUTY ROLLY DEPUTY MEDICAL EXAMINER Address (Greet, city, town or county) 23a BURIAL, CREMATIDN, DATE THEREDA 23d LOCATION (City or Town) (State) REMOVAL (Specify) Valleio. Abbeu of the Chines California 25a. REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE Georgia Ave VR A15ME (5) Silver Spring 6M 1/67 Fumphrey. Inc.



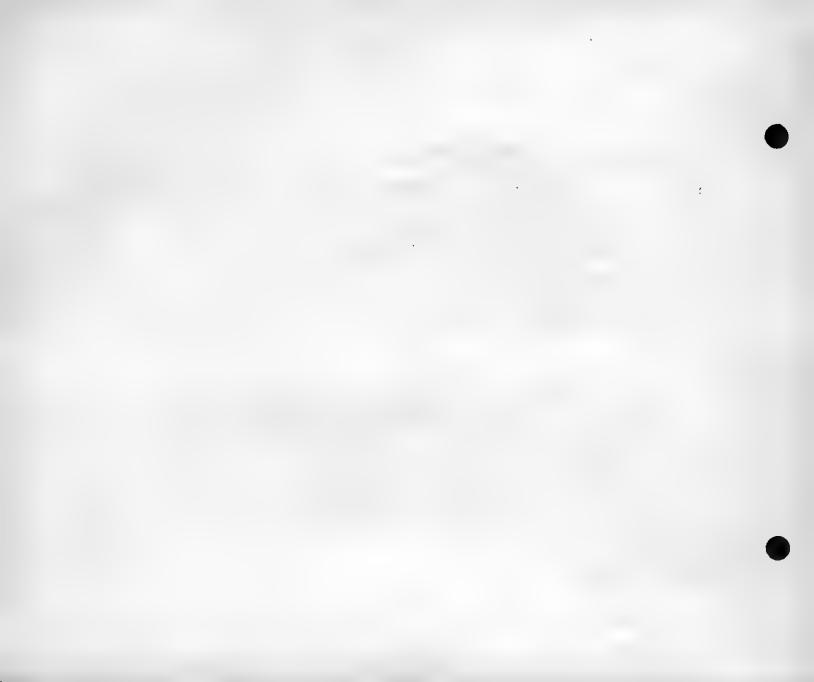
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12578 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. COUNTY o STATE b COUNTY = omac MARYLAND b CITY OR TOWN (If outside corporate limits. C LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate emits, write RURAL and give nearest town) write RURAL and give-pearest town the death certificate be executed within 24 hours e IS RESIDENCE d. NAME OF HOSPITAL OR INSPITATION (If not in hospital, give street oddress) d STREET ADDRESS ON A FARM? filled NO N NAME OF . First Middle DATE Day Year DECEASED OF W. 25 DEATH 1967 (Type or print) S SEX 9 AGF (In years 6. COLOR OR RACE DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS 7 MARRIED NEVER MARRIED remove prost bipthday) Days Sancagy. WIDOWED DIVORCED 100 USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY lousewife 13. FATHER'S NAME 14 MOTHER'S MAIDEN 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMAN Addres (Yes, no, or unknown) (If yes give wor or dates of service) Ö INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (q) (b), and (c).) burial-transit PART I. DEATH WAS CAUSED BY: ONSET AND DEATH requires that IMMEDIATE CAUSE (6) DHF TO Conditions, if ony, which gove ) rise to immediate couse (o). DUE TO stating the underlying couse PART IF OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) WAS AUTOPS' NO 7 ٥ 20o ACC DENT WAS UNDERLYING □ 206 DESCRIBE HOW INJURY OCCURRED (Exter nature of injury in Part 1 or Part I) of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form (City or town) (County) (Stote) Not While foctory, street, office bldg, etc.) 21. I certify that (1) (this haspital) attended the deceased fram \_\_, that (I) (we) las Dry 19 M, from causes and an the date stated above DIRECTOR: saw the deceased alive an , and that death accurred at 220. SHONATURE 22b DATES GNED ATTENDING DIRECTOR M.D director, page 22c. PHYSICIAN'S 22d ADDRESS 230\_BUR AL, CREMAT, ON 23b DATE THEREOF 23d LOCAJION\_(City or Town) 23c. NAME OF CEMETERY OR CREMATORY r.d Cedar Hill CREMOYAL (Specify)O 17 Crematory Surviand 0 thesda Md Ave



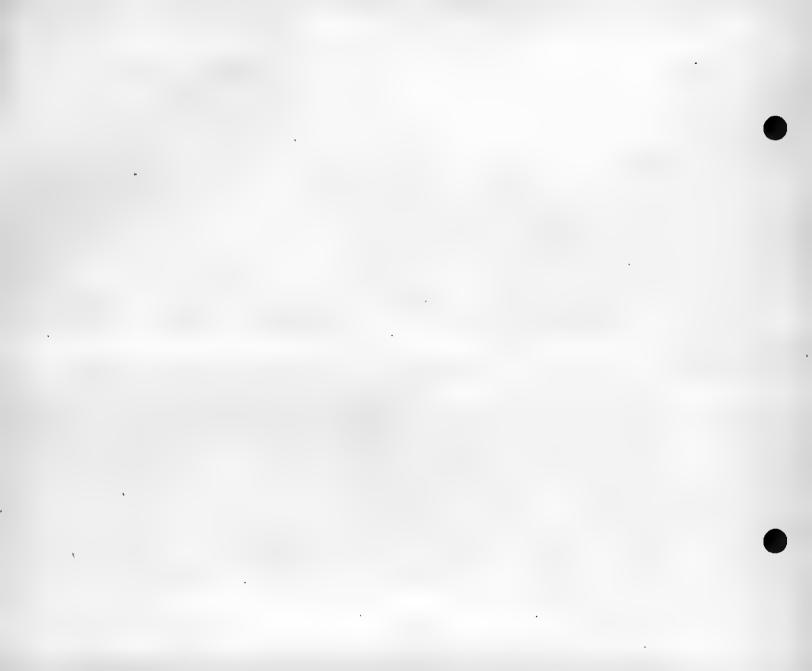
-	DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, M. 12570 CERTIFICATE OF DEATH
1,	PLACE OF DEATH  1 Ontgomery  MARYLAND  2. USUAL RESIDENCE (Where decessed lived, if institution, Rame of the county of the count
	b. CITY OR TOWN (if outside corporate limits, write RURAL and gwrite RURAL and give nearest town)
_	Gaithersburg Gaithersburg
	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress)  d STREET ADDRESS  (Chestnut Street
3.	NAME OF First Middle Last 4. DATE Month OF
Ļ	(Type or print) Eugenia Athelia Childers Sept 4th
	last birthday Months D
-	B. USUAL OCCUPATION (Give kind of work   10b. KIND OF BUSINESS OR INDUSTRY   11. BIRTHPLACE (County & State, or foreign country)   12. CITIZ
do	one during most of weighing life, even if retired)
13	FATHER'S NAME  14. MOTHER'S MAIDEN NAME
	Eugene D. Liller Lillian E. Simms
	WAS DECEASED EYER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address
1,11	218-20-2430 Kathrleen E. Hanna, Gaithersbu
	18. CAUSE OF DEATH (Enter only one cause par line for (e), (b), and (c).)
	PART I. DEATH WAS CAUSED BY: Heart Failure
	DUE TO
	Conditions, it any, which ) 161 Metastatic Breast Carcinoma
	gava rise to immadiate cause  (a), stating the underlying DUE TO
	cause last. (c)
S ≥	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1
3	
L CERTIFICATION	20a. ACCIDENT WAS UNDERLYING   20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING   CAUSE OF DEATH   (IF EITHER, NOTIFY MEDICAL EXAMINER)
WEDICAL	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, farm, 19 at work at work 19 at work
12	21. I certify that (I) (this hospital) attended the deceased from 1/30
2	saw the deceased alive on 9/1 1 1967, and that death occurred at 3 1/2.M, from the causes and on the
2	22a SIGNATURE
3	ATTENDING MED STACE
2	Melum d Gradon M.D ATTENDING MED. STAFF PHYS.   MED. STAFF PHYS.   PHYS.   OF THE
2	Melun d Colon ATTENDING MED. STAFF PHYS. DIRECTOR P
	Melun J Gran M.D PHYS. ATTENDING MED. STAFF DIRECTOR DIRECTOR PHYS. DIRECTOR DIRECTOR DIRECTOR DIRECTOR DIVING GO
	Medum J Gradon M.D ATTENDING MED.  22c. PHYSICIAN'S NAME (Type) Medun J. KORDON MD 13 Deer Pouls Drive Go  a. BURIAL, CREMATION, 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, fown or county)  REMOVAL (Specify)
23	MED ATTENDING MED.  22c. PHYSICIAN'S NAME (Type) MELVIN J. KORDON MD 22d. ADDRESS 13 Deer Pauls Drive Go  a. BURIAL, CREMATION, 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, fown or county) Burial 9-6-67 Park Lawn Rockyille. Md.
23	Medum J Gradon M.D ATTENDING MED.  22c. PHYSICIAN'S NAME (Type) Medun J. KORDON MD 13 Deer Pouls Drive Go  a. BURIAL, CREMATION, 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, fown or county)  REMOVAL (Specify)



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 2571 12580 CERTIFICATE OF DEATH hin 72 hours after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o STATE b. COUNTY outgomer MARYLAND b CITY OR TOWN (If outside Amporote limits c. LENGTH OF STAY IN 1h c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) The law requires that the death certificate be executed within 24 hour ⊆ OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d STREET ADDRESS e IS RES DENCE ON A FARM? filled North YES NO [ DATE OF DEATH NAME OF Cocban Doy Year and campletely DECEASED ar remaval, and in any event, Type or print) Sept. /3 SEX 7. MARRIED NEVER MARRIED remove lost birthday) Months Doys Hours WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR BIRTHPLACE (County & Stote, or loreign country) 12 CIT ZEN OF WHAT during most of working life even if retired) please the attending physician sit permit. Then please Mer Eng lang 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME 17. INFORMAN Address (Yes, no, grunknown) (If yes give war or dates of service) be detached far use as the burial-transit pern State Dept. of Health priar ta burial, crematian, No 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), PART 1. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (o) Page 4 may be retained by the haspital ar attending physician. DUE TO Conditions, if ony, which gove rise to immediate couse (a). DUE TO stating the underlying couse certificate has been last. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPS PERFORMED? NO 200. ACCIDENT WAY UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED (Enter notuse of injury in Port I or Port II of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER! MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour o.m. lactory, street, office bldg , etc ) Not While 10 FUNERAL DIRECTOR: After ot work 21. I certify that (1) (this hospital) attended the deceased fram director, page 3 should should be filed with the saw the deceased alive an and that death occurred at M. from causes and on the date stated obave 22o. SIGNATURE 22b DATE SIGNED ATTENDING M.D PHYS DIRECTOR PHYS PHYSICIAN S NAME (Type) 22d. ADDRESS BURIAL, CREMATION, NAME OF CEMETERY OR CREMATOR (Stote) 24. FUNERAL DIRECTOR VR A15 (4) 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 2581 CERTIFICATE OF DEATH death. PLACE OF BEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. COUNTY b. COUNTY Montgomery Maryland after Montgomerv MARYLAND b. CITY DR TDWN (if outside corporate limits, write RURAL and give nearest town)
Silver Spring c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b hours Silver Spring E d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS 8. IS RESIDENCE ed ON A FARM? 514 Deerfield 514 Deerfield Avenue within Ave. ND X YES etely bon p within NAME DE DECEASED First Last 4. DATE Month Middle DF DEATH DAVTE (Type or print) CHOPNITCK Sent. 67 19 6. COLDR OR RACE AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS 5. SEX and para DATE OF BIRTH 7. MARRIED X NEVER MARRIED last birthday) | Months | Davs Hours Male white 189 WIDOWE DIVORCED [ 10a, USUAL DCCUPATION (Give kind of work done, 10b KIND DF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT B ease during most of working life, even if retired)
Furniture Retailer INDUSTRY CDUNTRY? Furniture Foll and death certificate Then plane 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ing Wy Then p Morris Aaron Chopnick Sadie Snider 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SDCIAL SECURITY NO. 17. INFORMANT Address transit permit (Yes, no, or unknown) (If yes give war or dates of service) Morris Miller 509 Mansfield kd. unknown SSpg. INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). burial-transit burial, cremat The law requires that the ONSET AND DEATH PART I. DEATH WAS CAUSED BY: attending physician. IMMEDIATE CAUSE (a signed DUE TO Conditions, If any, which (b) been gave rise to immediate the DUE TO cause (a), stating the underlying cause last. as i CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? certificate MD 7 YES PHYSICIAN: DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part | or Part | of Item 18.) 20a. ACCIDENT WAS UNDERLYING F Led f DR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL (State) 20c. TIME DE INJURY Month, Day, Year 20d, INJURY OCCURRED 20e, PLACE OF INJURY (Home, farm, 20f. (City or town) (County) factory, street, office bldg., etc.) Hour a.m. While Not While After be ATTENDING at work at work be retained ge 3 shouseled with the that (I) (we) last 21. I certify that (i) (this hespital) attended the deceased from death occurred at 11200M, from the causes and on the date stated above. saw the deceased alive pro-196 and that 22a. SIGNATURE page ATTENDING PHYS. DIRECTOR M.D. may TO HOSPITAL FINIRIL ADDRESS 22c. PRYSICIAN'S director, 1 NAME (ype) (State) BURIAL, CREMATION. 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) REMOVAL (Specify) 196 Natl. Burial Mem. Park Falls Church CT 3 1967 ADDRESS 24. FUNERAL DIRECTOR Cleary VR A15 (4) Goldberg Funeral Home 20M 1/65



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12582 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. COUNTY b. COUNTY Montgomery Pennsulvania Lycomina . MARYLAND b CITY OR TOWN (I autside corparate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate lamits, write RURAL and give nearest town) c LENGTH OF STAY IN 16 Silver Spring 12 days Williamsport d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) S RESIDENCE ON A FARM? d. STREET ADDRESS 708 Posemere Street Silver Spring. Md 1391 Almond Street YES NO D NAME OF Lost 4 DATE First Month Yeor DECEASED OF DEATH Sept 1967 Clark Pearl (Type or print) B DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS S SEX 9. AGE (In years 6 COLOR OR RACE 7 MARRIED NEVER MARRIED last burthday) Months Haurs Aug. 4, 1897 White gemale. d for use as the burial-transit permit. Then please rema of Health prior to burial, cremation, or removal, and in any WIDOWED DIVORCED 10a USUA, OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CIT ZEN OF WHAT during most of working I le, even if retired) COUNTRY ? Own Home Williamsport, Pa, 14. MOTHER'S MAIDEN NAME 13 FATHER'S NAME Sarah Jesse 1 17. INFORMANT 16. SOCIAL SECURITY NO. (Yes, no grunknown) (If yes give war or dates af service) C. Hoover 708 Rosemere Street, SS. Mc 183-40-6930 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) DUE TO Conditions, if ony, which gove rse ta immediate couse (a), DUE TO stoting the underlying couse O FUNERAL DIRECTOR: After this certificate has been PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPS) PERFORMED? NO . 🔀 20g. ACCIDENT WAS UNDERLYING [1] 20b. DESCRIBE HOW INJURY OCCURRED, (Enter noture of injury in Part 1 or Part 11 of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER director, page 3 should be detache should be filed with the Stote Dept. (City or town) 20c. TIME OF INJURY Manth, Day, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (County) (Stote) Nat While factory, street, office bldg., etc.) 19<u>≤7</u>, ta\_ 1/10 , 19<u>47</u>, that (I) (we) last 21. I certify that (I) (this haspital) attended the deceased fram. 19 27, and that death accurred at \$ 15 2M, from causes and an the date stated above saw the deceased alive on\_ 22o. SIGNATURE 22b. DATE SIGNED MED. DIRECTOR M.D. 22d. ADDRESS 22c. PHYSICIAN'S 10. Nealon NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION, 23b. DATE THEREOF (County) REMOVAL (Specify) Williamsport. Lycoming Pa. emeteru 9/14/67 (0. 2So. REC D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (4) 20 M 1/66 James E. Pumphrey Inc. 8434 Georgia Ave S.S.



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12583 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission Montgomery MARYLAND O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours offer C. LENGTH OF STAY IN 16 b CITY OR TOWN (If outside corporate amits. c CEX OR TOWN (If outside corparate limits, write RURAL and give nearest town) write RURAL and give-nearest town) d NAME OF HOSPITAL OR INSTITUTION (Whot in hospital, give street address) ON A FARM YES NAME OF DECEASED OF DEATH (Type or print) IF UNDER 9. AGE (In years 6. COLOR OR RACE lost birthday) Months Dovs Hours WIDOWED DIVORCED 10g USUAL OCCUPATION (G ve kind of work done 10b, KIND OF BUSINESS OR 12 CITIZEN OF WHAT during most of working life, even if retired) ouséwife 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME J. Adams or removo Minnie James Aaron Mills 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT Fusband (Yes, no, or unknown) (If yes give wor or dates of service nl.nevn Same as Ttem 2. Raymond Clark 18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c))
PART 1 DEATH WAS CAUSED BY:
Particles T. INTERVAL BETWEEN PerudentLobularPneumonia IMMEDIATE CAUSE (o) DUE TO BronchogenicCarcinoma; RightLung Conditions, if ony, which gove rise to immediate couse (a), DUE TO stating the underlying couse last. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO. 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part II of item 18.) 20o ACCIDENT WAS UNDERLYING [ OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e, PLACE OF INJURY (Home, form, (City or town) (Stote) 20c. I.M.E. OF INJURY Month, Doy, Year 20d INJURY OCCURRED (County) Hour a.m. factory, street, office bldg , etc.) Not While of work 19 67, that (I) (we) last 21 I certify that (1) (this haspital) attended the deceased from 2-57 19 6 2 and that death accurred at 52.40 P.M. from causes and an the date stated above saw the deceased alive an \_ 22o. SIGNATURE 22b DATE SIGNED M.D 22d ADDRESS Viers JONES 23c NAME OF CEMETERY OR CREMATORY 230 BURIAL, CREMATION. 23b. DATE THEREOF 23d LOCATION (City or Town) (County) Burial Specify) Parklawn Cometerv 9-28-67 Rockville. Maryland 250 RECD BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR VR A15 (4) PUM HRIY, Tothesda, Larylana Ochanles



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12584 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The law requires that the death certificate be exacuted within 24 heurs after death. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission o. COUNTY 12 b. COUNTY ontgomeri c. LENGTH OF STAY IN 16 IOWN (If outside corporate limits, write RURAL and give nearest town) NAME OF HOSP TAL OR INSPITUTION (If not in haspital, give street address) d STREET ADDRESS ON A FARM? 104 NAME OF Middle DATE DECEASED OF DEATH ugene 20 19 67 (Type or print) last birthday) IF JINDER 1 YEAR IF UNDER 24 HRS 7 MARRIED NEVER MARRIED WIDOWED DIVORCED 10g LSUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR iPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired INDUSTRY 9/11/14 13. FATHER'S NAME or removal. OAKEY IS WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMAN (Yes, no, or unknown) (If yes give war or dates of service IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY. INTERVAL BETWEEN e burial-tronsit p ONSET AND DEATH IMMEDIATE CAUSE (o) DUE TO Entrin Dellester Cardiovaccular design Conditions, if any, which gave ) rise to Immediate cause (a). **DUE TO** stating the underlying cause 19 WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? NO 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) Page 4 may be retained by the hospital 20g ACCIDENT WAS UNDERLIZING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, farm, (Cry or town) (County) (State) 20c, TIME OF INJURY Month, Doy, Year Hour om. factory, street, office bldg., etc.) Not While 1959, 10 Cenque 1967, that (1) (we) last 21. I certify that (1) (this hospital) attended the deceased from 1967, and that death accurred at 337 M, fram couses and an the date stated above saw the deceased alive an\_ 22a SIGNATURE 22d. ADDRESS TO FUNERAL 924/COLUMBIA BURIAL, CREMATION 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) REMOVAL (Speculy) 2Sq. RECD BY REGISTRAR FLINERAL DIRECTOR YR A15 (4) 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH death, 1. PLACE OF DEATH
a. COUNTY USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) MARYLAND b. CITY OR TOWN (if outside co porate limits) write RURAL and give nearest town) C. LENGTH OF STAY IN 1b c. CITY OR TDWN (If outside corporate limits, write RURAL and give nearest town) hours Chevy Chase d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? 6625 Hillandale within, Road NO 3 YES within etely NAME OF MIddle Last DATE Month Year DECEASED Combe DF DEATH 표 (Type or print) 196 AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS DATE OF BIRTH 7. MARRIED NEVER MARRIED last birthday) Months Davs WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work done | 10b. KIND OF BUSINESS OR during most of working life, even if retired) INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT death certificate be CDUNTRY? 13. FATHER'S NAME removal, MDTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT (Yes, no, or unkown) ((If yes give war or dates of service) 18. CAUSE OF DEATH [Enter only one cause per line for (a), PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) **DUE TO** Cenditions, If any, which (b) been gave rise to Immediate DUE TD cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(8) WAS AUTDPSY PERFORMED? certificate had for use YES [ ND X 20a. ACCIDENT WAS UNDERLYING TO DR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) HYSE MI: 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part 1 or Part 11 of Item 18.) CAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE DF INJURY (Home, farm, I 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour a.m. MEDI Not While 19 at work at work T 21. I certify that of (this hospital) attended the deceased from and that death occurred at 8 AM, from the causes and on the date stated above. saw the deceased alive on page filed DIRECTOR FUNERAL ADDRESS PHYSICIAN'S 22d. director, p BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) Suitland. Haryland Gremation Cedar hill FUNERAL DIRECTOR Bethesda, Maryland 196 VR A15 (4) 20M 1/65



2-1-1	I tems 10-20 Film 393 MARYLAND STATE DEPARTMENT OF HEALTH 10-10-67 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	
FOR STATE	1257 MEDICAL EXAMINER'S CERTIFICATE OF DEATH	12586
HEALTH DEET	1 PLACE OF DEATH 2 USUAL RESIDENCE (Where descosed lived, if institution: Residence in the control of the contr	dence before admission)
of ge of	o. COUNTY MONT gome i y MARYLAND STATE TILE. b. COUNTY	Monte
delay is and 3 to M3. Page rt ment of	b CITY OR TOWN (If outside corporate limits, write RURAL and confidence of the confi	give nearest town)
y delay is and 3 to PM3. Page art ment of	132 thesas years (years. 150 the sale	11
0 2	d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)   d STREE ADDRESS	B IS RESIDENCE ON A FARM?
form form	7823 Custer Rd. 1823-Custer X	YES NO
r death If ony delay is ve Pages 1, 2, and 3 to 3 with form PM3. Page the State Department of	3 NAME OF DECEASED (Type or print) Louise Hercler Corry OF DEATH Sert	Doy Year 27 19 6 7
after along with	S SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 8 DATE OF BIRTH 9 AGE (n years   FUND	ER I YEAR I IF UNDER 24 HRS
18. 18. 0	7-e. W- WIDOWED DIVORCED Dec. 21, 1905 lost betridoy) Months	s Doys Hours Min
haun Tem Ond dec	10a USUAL OCCUPATION (Give kind of work done done done done done) 10b KIND OF BUSINESS OR 11 BIRTHPLACE (State or foreign country) 12 during most of working life, even if retired) INDUSTRY	CITIZEN OF WHAT
hin 24 haurs nail in Item 11 niners Office poges Iond 2 v	Housewife Maryland.	COUNTRY?
hin ncil nine pog	13. FATHER'S NAME	
× pe xou	Henry W. Heider Elizabeth Dernn Is was deceased ever in us armed forces? To social security no 117 informant Browner 630 and 630.	and David
ficote should be executed within 24 haurs ing the word 'pending' in pencil in Item 18 rded to the Chief Med col Examiners Office as o buriol-transit permit. Fle pages I and 2 vand in any event within 72 hours after death	(Yes, no or unknown) (If yes give war ar dates of service)	
Med Med w this		INTERVAL BETWEEN
be e 'per 'per lief /	18 CAUSE OF DEATH (Enter only one couse per line for (o), (b) ond (c),) PART 1 DEATH WAS CAUSED BY: IMMEDIATE (AUSE (o) PROJECT OF Barbiturate poisoning & drowning	ONSET AND DEATH
ord ord e Ch Il-tro	DUE TO	
shore we was the surrection and	Conditions, if only, which gove (b) Overdose of barbiturates	
of the din din	stating the underlying couse DUL TO	
t.fico ut ng arde d as d as	lost. (c)  PART I OTHER SIGN F CANT CONDIT ONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE COND T ON GIVEN IN PART 1(c)	10 WAS A ITODGY
MEDICAL EXAMINER: This certificate should be executed within 24 haurs after death. If please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, I director. Page 4 should be forwarded to the Chief Med cal Examiners Office along with form retained for your files.  DIRECTOR: Page 3 should be used as a burnol-transit permit. Fle pages I and 2 with the State Day to burial, cremation, or removal, and in any event within 72 hours after death	A CONTRACTOR OF THE CONTRACTOR	19 WAS AJTOPSY PERFORMED? YES NO
the The thical of reformed to the contract of	200 EXTERNAL CAUSE WAS 200 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18) PRIMARY D or CONTRIBUTING D CAUSE OF DEATH TOOK overdose of barbiturates and submer	€;=d
INER: e cert shoul files. 3 shou	20c TIME OF INJURY Month, Day, year 20d INJURY OCCURRED 20e PLACE OF NIJURY (Mome, form, 20f (City or town) (	(County) (Stote)
AMI e the bur oge	7 ?Hour a.m. Sept27 19 67 While Not While I foctor, street, office bldg, etc.) Bethesda Mont	gomery Md.
EX ecut Poge 2: Pog	21. I certify that I taak charge of the remains described above, held an Autapsy 🐼, Inspect an 🔼, Inquiry 🄀	<u> </u>
MEDICAL EXAMINER: please execute the cert- director. Page 4 should etained far your files. DIRECTOR: Page 3 shoul to burial, cremotion, or	death resulted fram. Natural causes 🔲 , Accident 🔲 , Suicide 💢 , Hamicide 🔲 , Undetermined manner	
PEC POSE POSE POSE POSE POSE POSE POSE POSE	ACTUAL CHIEF MEDICAL EXAMINER C	22. DATE SIGNED
ol d	SIGNATURE MD ASSISTANT MEDICAL EXAMINER 7/29/2	7 - 22. DATE SIGNED
DEPUTY MEDICAL EXAM pressory, please execute the funeral director. Page 4 may be retained for your FUNERAL DIRECTOR: Page eaith prior to burial, cremoin	EXAMINER'S NAME (Type) Address (Street, city town, or county) Pathes	da, Ma.
TO DEPUTY MEDICA necessory, please existe funeral director. S may be retained 1 TO FUNERAL DIRECTO Health pr or to buric	230 R. PIÁL CPEMATION 235 DATE THEREOF 237 NAME OF CEMETERY OF CREMATORY 230 10(ATION (CAU OF TOWN)	(County) (State)
7 4 5 2 4	Lurid 9-30-67 Rock Creek Cenevary Washington.	D. C.
VR A15ME (5) 6M 1/67	24 FUNFRAL D RECTOR ADDRESS 2SO REC'D BY REGISTRAR   2SO REGISTRAR	s SIGNATURE
		100







\ 1 ~	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
1 × 3		125.0 CERTIFICATE OF DEATH	12529	
The death		o. COUNTY mortgones MARYLAND O. STATE Md.	lived, if institution Residence before admission) b COUNTY Northorners limits, write RURAL and give neares (awn)	
N N N		d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  d. STREET ADDRESS	e is residence	
filled in 24		Holy laver Hospital 2019 Han	one St YES NO	
coupletey fill to ye completely fill to ye completely fill to ye company		A market and a second a second and a second	Month Doy Year  9 - 1 19 67  ACE (In years   FUNDER 1 YEAR   FUNDER 24 MRS   lost pryhdoy)   Months Doys Hours   Min	
tian and co	duri	USUAL OCCUPATION (Give kind of work done ing most of working life, even if retired)  Widowed Divorced Boundary 8 June 100 KIND OF BUSINESS OR II. BIRTHPLACE (County & State, or foreign most of working life, even if retired)  Western Electric Washington, D.C.	gn cauntry) 12 CITIZEN OF WHAT	
ertifica physi nen pl iaval,		FATHER'S NAME  14. MOTHER'S MAIDEN NAME  Clay V. Davis  Sidney Rochest	er	
e death certificate b attending physician permit. Then please on, ar remaval, and i	15.	WAS DECEASED EVER IN U.S. ARMED FORCES? as, no, or unknown) (If yes give war or dates of service) 577-07-8618 Mrs. Dorothy C. Davi	Address 2019 Hanover Street	
the usit the most		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a)  DUE TO  Canditions, if ony, which gove )  (b)	INTERVAL BETWEEN ONSET AND WEATH en order 7	
The law requires th attending physician has been signed so as the burial-traith priar ta burial, cre		rise to immediate cause (a), storing the underlying couse (c) Concrete ast.	2 725	
The land at a transfer at a tr	ATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN	IN PART I(0)  IP. WA FAUTOPSY PERFORMED? YES NO	
TO HOSPITAL OR ATTENDING PHYSICIAN: The Page 4 may be retained by the haspital at all TO FUNERAL DIRECTOR: After this certificate hadirectar, page 3 should be detached far use shauld be filed with the State Dept. af Health	CERTIFIC	20a ACCIDENT WAS UNDERLYING  OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II		
NG PHYSIC  If the hasping the this certice defacted are Dept. of	MEDICAL	Haur o m. While Not While factory, street, affice bldg., etc.)	(City or tawn) (County) (State)	
ATTENDING stained by the CTOR: After 1 should be do if the State of th		21. I certify that (1) (this kespital) attended the deceased fram (1) (c) 1963, to saw the deceased glive in 1963, to 1962, and that death accurred at 1.40 M,		
OR AI OR AI DIRECT OR AI		22a. SIGNATURY MED. M.D. PHYS. DIRECTOR	STAFF 22b. DATE SIGNED	
Page 4 may be refained Publication of Funeral Directors: A director, page 3 should should be filled with the		22c PHYSICIANS NAME (Type) KIF Kreuzburg 22d. ADDRESS 7852-162	BAINW. D.C.	
TO HOSPITAL Page 4 may TO FUNERAL I director, pag shauld be fill	230	RFMOVAL (Specify)	ATION (City or Town) (County) (State)	
VR A15 (4)	24	FUNERAL DIRECTOR C. Glen Carter (DDAES) Calc. 250. SEP BY REGISTRAL	1967 25b. REGISTRAR'S SIGNATURE	



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12590 CERTIFICATE OF DEATH 600 L The law requires that the death certificate be executed within 24 haurs after death. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. COUNTY b. COUNTY MARYLAND b CITY OR TOWN (It outside corporate/limits, C LENGTH OF STAY IN 16 outside corporate limits, write RURAL and give nedrest town) (If not in hospital, d STREET ADDRESS IS RESIDENCE ON A FARM? pop NO NAME OF 4./DATE Year. DECEASED OF DEATH Type or onnt and in any even LINDER 24 HRS AGE 7. MARRIED remave Jos birthdovi Months Hours DIVORCED WIDOWED and 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT attending physician ( sermit. Then please INDUSTRY **COUNTRY? EATHER S NAME** 13 14. MOTHER'S MAIDEN NAME burial, crematian, or removal, INFORMANT 16. SOCIAL SECURITY NO (no, ar unknown) (If yes give wor or dates of service INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per fine for (o), (b), and (c) )
PART I DEATH WAS CAUSED BY. signed by the ONSET AND DEATH burial-transit IMMEDIATE CAUSE (a) Page 4 may be retained by the hospital ar attending physician. DUE TO Conditions, if ony, which gove rise to immediate couse (a). DUE TO stoting the underlying couse has been director, page 3 shauld be detached far use as the shauld be filed with the State Dept. of Health priar ta lost WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN NO this certificate 200 ACC DENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of Item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or fown) (County) (Stote) 20c TIME OF INJURY Month, Day, Year Hour o.m. factory, street, office bldg., etc.) Not While at work 21. I certify that (1) (this haspital) attended the deceased from and that death accurred at how 1967 O FUNERAL DIRECTOR: saw the deceased alive an \_M, fram causes and an the date stated above. 22o. SIGNATURE 22b STAFF M.D PHYS DIRECTOR 22d. ADDRESS 22c PHYSICIAN'S NAME (Type) 236 DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 230 BURIAL CREMATION (County) (Stote) REMOVAL (Specify) Woodlawn Cemetery ENANN & Son Funerab HADDRESS 250 REC'D BY REGISTRAR 2Sb REGISTRAR'S SIGNATURI VR A15 (4) 25M 1/67 Georgia Ave N.W.



277	MARYLAND STATE DEPARTMENT OF HEALTH			
		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		
	5) 1	1258일 CERTIFICATE OF DEATH 12	591	
	rs after deoth y the tagend Pages and Just after terth	1. PLACE OF DEATH  o COUNTY  b CITY OR TOWN (If Outside corporate limits, write RURAL and give nearest limits, write RURAL and give nearest limits).	0.	
	completely filled in by love carbon popers. Payevent, within 72 haurs	d. NAME OF HOSP TAL OR INSTITUTION (If not in hospital, give street oddress)  Dether da - S: /var Mursing Home 6313 12th 61.  3. NAME OF First Middle Lost 4 DATE Month Day	IS RESIDENCE ON A FARM? VES NO Year	
	ote be executed victor and complete ease remove cart and in any event,	(Type or print)  S. SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9 AGE (In years lost birthday)  Fenale Hebrew WIDOWED DIVORCED CT. 190 Sost birthday Fig.  100. USUAL OCCUPAT ON (Give kind of work done during most of working lite, even if retired)  10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & Stote, or foreign country)  11 BIRTHPLACE (County & Stote, or foreign country)  12 CITIZEN OF COUNTRY?  13 COUNTRY?	19 C 7 IF UNDER 24 HRS. Hours Min WHAT	
	ne death certifica ottending physi permit. Then pl ion, or remaval,	13 FATHER'S NAME  APATHAM SOROTO  15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service)  219-14-077745VAD. MEYERSON FOCKEVILLE.	WEIND.	
	TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after deoth Page 4 may be retained by the hospital or ottending physician.  TO FUNERAL DIRECTOR: After this certificate has been signed by the ottending physician and completely filled in by the Lugary director, page 3 should be detached for use as the burial-transit permit. Then please remake carbon pagers. Pages and should be filled with the State Dept. of Health prior to burial, cremation, or remakal, and in any event, within 72 haurs after the characteristics.	18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)  PART 1. DEATH WAS CAUSED BY.  IMMEDIATE CAUSE (o)  DUE TO  Conditions, if any, which gove rise to immediate cause (o), stating the underlying couse lost.  (c)	AND STATH	
AN: The la al or offent of or offent licote has be for use os Health prior		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBLTING TO DEATH BUT NOT RELATED TO THE TERMINAL D.SEASE CONDITION GIVEN IN PART I(o)  YE  200 ACCIDENT WAS JNDERLYING  OR CONTRIBUTING CAUSE OF DEATH	WAS AUTOPSY PERFORMED? S NO	
	inc physical participation of the hospiter this certification of detached tate Dept. of	20c TIME OF INJURY Month, Doy Year Hour om p.m 19 20d INJURY OCCURRED While of work of	(Stote)	
	OR ATTEND be retoined by JIRECTOR: Af e 3 should be ed with the S	saw the deceased alive appear 1957, and that death accurred after M, from causes and on the date  220. SIGNATURE  M.D. ATTENDING MED DIRECTOR PHYS. PHYS.		
	D HOSPITAL Page 4 may D FUNERAL I director, pag should be fil	22c. PHYSICIAN'S NAME (Type) BLAINE H. EIG PG41 Colombelled Leberley  23g. BURIAL, CREMATION, 23b DATE THEREOF 23G NAME OF CEMETERY OR CREMATORY  23g. BURIAL, CREMATION, 23b DATE THEREOF 23G NAME OF CEMETERY OR CREMATORY  23g. YOCATION (City or Town) (County)  23g. YOCATION (City or Town) (County)	(State)	
	VR A15 (4) 25M 1/67	C4. FUNERAL DIRECTORY LECTORY	udge	



1	DIVISION OF VITA	MARYLAND STATE DEPARTMENT OF HE AL RECORDS, 301 W. PRESTON STREET, BALTIM	
The Park	12583	CERTIFICATE OF DEATH	12592
the funeral safter death	1 PLACE OF DEATH  o COUNTY  M O NT GOM  b CITY OR TOWN (If outside corporate limits	ERY MARYLAND O STATE MA	(Where deceosed lived, if institution: Residence before odmission)  RYIAND  b. COUNTY  HOWARD  outside corporate limits, write RURAL and give nearest town)
d within 24 hours after filled in by the parton, papers Pages nrt, within 72 hours aft	write BURAL and give nearest fown)  SILLER SPRINGS  d NAME OF HOSPITAL OR INSTITUTION (If not in hospi	5 14 days 5, m  Indo, give street oddress) d STREET ADDRESS	PSONVILLE BISRISDENCE ON A FARM?
completely filled in by the completely filled in by the cove corton papers. Page: y event, within 72 hours of	3. NAME OF DECEASED (Type or print) 5 SEX 6 COLOR OR RACE 7 MAR	Middle  R. DORSEY  RIED NEVER MARRIED   8 DATE OF BIRTH	4 DATE OF DEATH  9 AGE (In years lost birthday)  9 AGE (In years lost birthday)  19 Months Days Hours Min.
that the death certificate be execu- ion.  by the ottending physicion and con- tronsit permit. Then please remove cremation, or removal, and in any ev-	IDO USUAL OCCUPATION (Give kind of work done during most of working life, even if refired)  13. FATHER'S NAME		y & State or foreign country)  RYIANO  12 CIT ZEN OF WHAT COUNTRY?  COUNTRY?
ne death certiin of the other o	JOHN RALDH DOR DIS WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service)	16. SOCIAL SECURITY NO 17 INFORMANT WHS NAWCY POR	Address RSEY 117 VISTA ROAD
physici physical physici physici physici physici physici physici physici physi	18. CAUSE OF DEATH (Enter only one couse per lin PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  Conditions, if ony, which gove rise to immediate cause (o), stoting the underlying cause (c)	Prolice failure  Arin' Skun Swell	INTERVAL BETWEEN ONSET AND DEATH  199  109  100  100  100  100  100  10
TO HOSPITAL OR ATTENDING PHYSICIAN: The law re Poge 4 may be retained by the hospital or ottending TO FUNERAL DIRECTOR: After this certificate has been director, page 3 should be detached for use as the should be filed with the State Dept. of Health prior to	CATION	ING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CO OB DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in	YES NO
by the hospital flater this certification be detached for State Dept. of He	p.m. 17 0	Dd INJURY OCCURRED 2De PLACE OF INJURY (Home, for factory, street, office bldg, etc. stwork at work	
D HOSPITAL OR ATTEND Poge 4 moy be retained the S FuneRAL DIRECTOR: Af director, page 3 should be should be filed with the S	21. I certify that (I) (this hospital) a saw the deceased alive at 220, SIGNATURE	ive , and that death accurred a	MFD.  STAFF DIRECTOR  STAFF DI
O HOSPITAL O Poge 4 moy be O FUNERAL DII director, page should be filed		22d ADDRESS 22d ADDRESS 22d ADDRESS 22d ADDRESS	or Spring and
TO HO Poge TO Fun direct	230 BURIAL, (REMAT ON, REMOVAL (Specify) 23b DATE THEREOF 25b DATE THEREOF	67 LOUDON PARK	23d LOCATION (City of Town) (County) (Stote)  BACILIFICAC HABYLAND  D BY REGISTRAR 25b REGISTRARS SIGNATURE
VR A15 (4) 25M 1/67	HARRY WITZKE COLYMBIA	to the second se	



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12593 CERTIFICATE OF DEATH majoires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) funero a COUNTY o. STATE b. COUNTY MONTGOMERY MARY! AND MARYLAND MONTGÖMERY b CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) 35minutes GAITHERSBURG OLNEY .5 d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? MONTGOMERY GENERAL RT 2 Box 114 NO 5 YES NAME OF First Middle Lost DATE Month Year DECEASED OF VIRGIL DOVE (Type or print) OSWALD 29 19 67 DEATH 9. AGE (In years 6. COLOR OR RACE DATE OF BIRTH IF UNDER 1 YEAR IF JNDER 24 HRS 7 MARRIED **NEVER MARRIED** last birthday) Manths Days WIDOWED DIVORCED 7-7-06 MALE WHITE 10a. USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 12 CIT ZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) **COUNTRY?** puo LANDSCAPE GARDENE TISA 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME or removol, SERAH LOWRY BENJAMIN DOVE 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT 16 SOCIAL SECURITY NO. Address (Yes, na, or unknown) (If yes give wor or dotes of service) Samo 18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c). INTERVAL BETWEEN signed by the buriol-tronsit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Canditions, if any, which gave rise to immediate cause (a). DUE TO stating the underlying cause last. hos PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY PERFORMED? NO DE certificate 20g ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port t or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF NJURY Manth, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Haur 'a.m. Not While factory, street, affice bldg, etc.) at wark ot work 21. I certify that (I) (this haspital) attended the deceased from 196 1, that (I) (we) las be retained My from causes and an the date stated above FUNERAL DIRECTOR: saw the deceased glive an New Y and that death accurred at 22a, SIGNATURE 22b. DATE SIGNED ATTENDING MED. DIRECTOR PHYS PHYS 22c. PHYSICIAN S ADDRESS NAME (Type) Dr. F. Moomau should 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY **BUR.AL CREMATION** 23d. LOCATION (City or Town) (State) (County) REMOVAL (Specify) Parklawn 10-2-67 Rockville Mont. ADDRESS UCT 3 1967 25b 24 FUNERAL DIRECTOR VR A15 (4) Francis H. Barber Laytonsville, Md. 25M 1/67 DATE

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MARYLAND STATE DEPARTMENT OF HEALTH



1-2- 1	Items 1821 Film 393 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	40.00
FOR STATE	12586 MEDICAL EXAMINER'S CERTIFICATE OF DEATH	12595
HEALTH DEPT.	1 PLACE OF DEATH  O. COUNTY D  O. STATE  MARYLAND  2 USUAL RESIDENCE (Where deceosed lived, if inst tuhon Res  O. STATE  MARYLAND	dence before odm ssion)
ath If any deray is ogges 1, 2, and 3 to the farm PM3 Page State Department of	b (ITY OR TOWN (If outside corporate inits)  c. LENGTH OF STAY IN 1b  c (ITY OR TOWN (If outside corporate hmits, write RURAL and give hearest) town)  Let Correct 40 2 /2 . D. A. Liver wife 2 / 32	
T-E A	d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  12 data at a xul ru, t for place 1242 to teledon it.	e IS RESIDENCE ON A FARM? YES NO K
de de	3 NAME OF DECEASED (Type or pnnt) First Middle Lgst 4 DATE Month OF COMPANY OF THE SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED B DATE OF BIRTH 9 AGE (In years IFUND	Doy Year 1967 DER I YEAR   IF UNDER 24 HRS
5 - 0 C = 3	WIDOWED DIVORCED 6-13-30 Iost butbdoy) Month	S Days Hours Min
executed within 24 haurs nding" in pencil in Item 1. Medical Examiners Office permit. File pages land 2 within 72 haurs after death	100 USUA. OCCUPATION (Give kind of wyl) dona get 10b KIND OF BUSINESS OR 11 BIRTHPLACE (Store or fore gn country) 12  during most of working the same of the same	CUNTRY? A.
executed within inding" in pencil Medical Examine permit. File pag within 72 haurs in	Samuer H. Davors Sz AxxXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	
be execute 'pending'' ef Medical nsif permit nt within 2	1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c))	Maryland INTERVAL BETWEEN
	PART   DEATH WAS CAUSED BY    HAMEDIATE CAUSE (a)   Acute coronary thrombosis    HameDiate Cause (a)   DUE TO   Cond Lons, if any, which gove ) (b)   Coronary artery heart disease	ONSET AND DEATH
e, writing the ward farwarded ta the C used as a burial-tr	storing the underlying cause last (c) DUE TO	
Th.s certificate, write be farwar be used removal,	PART I OTHER SIGN FICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(2)	9 WAS AUTOPSY PERFORMED? YES NO
MINER: Th.s. The certificate, thought be fault or files. e 3 shauld be to natian, ar rema	20a EXTERNAL CAUSE WAS PRIMARY CONTRIBUTING CAUSE OF DEATH CAUSE OF DEATH PRIMARY CONTRIBUTING CAUSE OF DEATH 20th TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF NJURY (Home form, 20f (City or fown)	(County) (State)
L EXAMINER: ecute the certi Page 4 shauld for your files. R: Page 3 shau al, crematian, a	Hour om pm 19 While of work of twork foctory, street, affice bidg, etc.)  21 I certify that I taok charge of the remains described above, held an Autopsy Inspection Inquiry	
MEDICAL EXA please execute director Page retained for yas DIRECTOR: Page r ta burial, crem	death resulted from: Natural causes , Academ , Suicide , Homicide , Undetermined manner	and in my opinian
O DEPUTY MEDICAL EXAMINER: This certineessary, please execute the certificate, writh the funeral director Page 4 should be farwally may be retained for your files. O FUNERAL DIRECTOR: Page 3 should be used Heaith prior to burial, cremation, ar removal.	SIGNATURE ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER	22 DATE SIGNED
TO DEPUTY necessary, the funeral 5 may be 10 FUNERAL Hea'th pria	NAME (Type) 3E DE X A DATE THEREOF 23C NAME OF CEMETERY OF CREMATORY 23d LOCATION (City or Town)  REMOVAL (Specify) 23b DATE THEREOF 23c NAME OF CEMETERY OF CREMATORY 23d LOCATION (City or Town)	(County) (State)
VR ATSME (5)	Open Correr John Janes John Conference Georges John Strage John Registrar John Re	S SIGNATURE



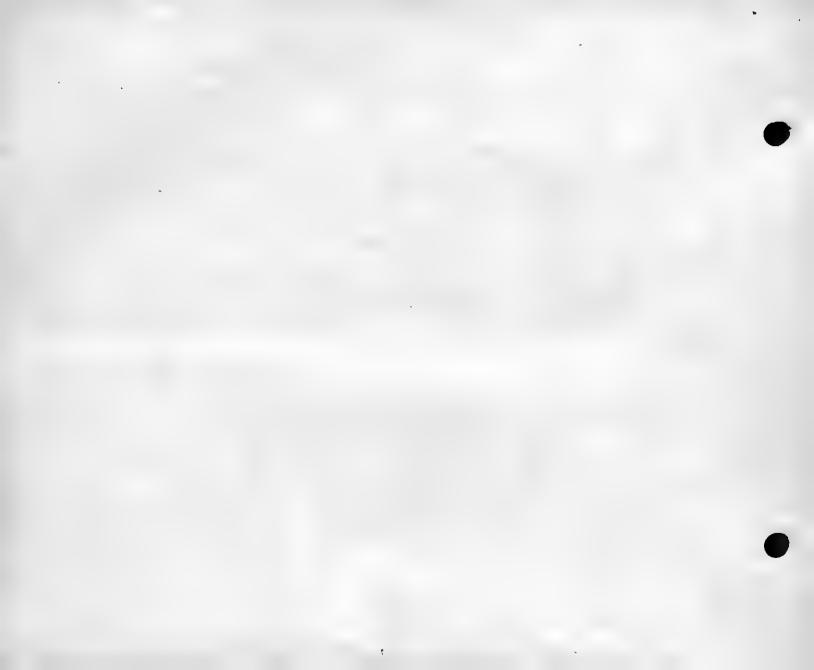
	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
4	ľ	49507				
	£ -2£	14090				
	r death uneral and 2	1 PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a COUNTY b, COUNTY				
	1 2 2	b CITY OR TOWN (If outside corporate mits, c LENGTH OF STAY IN 1b c CITY OR TOWN (If outside corporate fimits, write RURAL and give reares) town)				
	2	write RURAL and give nearest town) SILVER 34 days  TAKOMA PARK				
	hou hou	d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  d STREET ADDRESS 328 BOYD AVE.  e S. RESIDENCE ON A FARM?				
	filled in	COLONIAL LILA MURSING HOME 12325 New HOMESTING THE YES   NO [				
	the second	3 NAME OF First Middle Lost 4. DATE Month Day Year DECEMBED OF				
	npletely rearborn	(Type or print) MHRY EMMA DUM & PM DEATH OL 19 67				
	comp	S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED S DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HR				
	exe mud rem	TOO USUAL OCCUPATION (Give kind of work done)  NOTICE TO DIVORCED 2-14-1888 AS 100 MINISTRA NOTICE OF THE NOTICE OF WHAT				
	e be an c ase nd ir	during most of working file, even if retired) (OUNTRY)				
	fical ysici ple al, a	13. FATHER'S NAME // ) 14. MOTHER'S MAIDEN NAME				
	certi g ph Then mav	Detergues -				
	ndin iit.	15 WAS DECEASED EVER IN U.S. ARMED FOR CES? (Yes, no, or unknown) (If yes give wor or dates of service)  16. SOCIAL SECURITY NO. 17 INFORMANT.  Address 328 Poyla Like				
	atte perm an, c	18 CAUSE OF DEATH (Enter only one cause per tipe for (b), (b), and (c))				
	requires that the death certificate be executed within 24 hours after death a physician.  I signed by the attending physician and completely filled in by the funeral burial-transit permit. Then please remaye carban paper these and a burial, crematian, or remayal, and in any event, within 72 poor offer death a burial, crematian, or remayal, and in any event, within 72 poor offer death	PART I. DEATH WAS CAUSED BY. ONSET AND DEATH				
	s the	MMMEDIATE CAUSE (6) Colored Parameters Strapper Le Salay				
	quires th physician signed by burial-tra burial, cre	Conditions, if ony, which gove is to immediate course (a), (b) Citterie selecter carolic-vas inlan disease impension				
	ng pan si	stoting the underlying couse Due to				
	The law re attending has been se as the th priar tal	lost   Cc     Part II other significant conditions contributing to death but not related to the terminal disease condition given in part I(o)   19 Was autopsy				
	The state of the s	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(0)  19 WAS ALTOPSY PERFORMED? YES \(\bigcap \) NO [				
	AN: The of or at icate had far use Health i	200 ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Part 11 of Item 18.)				
	PHYSICIAN: e haspital ar his certificate trached far u Dept. af Heal					
	by the hospital ar fifer this certificate be detached for u State Dept. of Health	20c TIME OF INJURY Month, Doy, Yeor Hour o.m. 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.) (County) (Stote)				
	DING by th fifer I be d	p.m. 17 of work U				
	OR ATTENDING be retained by th NRECTOR: After to e 3 shauld be de ed with the State	21. I certify that (I) (this hospital) attended the deceased fram Line (5, 1967, ta Line), 1967, that (I) (we) I saw the deceased alive an Line (5, 1967, and that death accurred at 400 AM, from causes and an the date stated about				
	OR ATTENI be retained SIRECTOR: A e 3 shauld ed with the	220 SIGNATURE 220 DATE SIGNED				
	OR DiRE	Ociv Chap, M.D ATTENDING MED. STAFF   9-7-6-7				
	Page 4 may be retained by the hospital ar attending O FUNERAL DIRECTOR: After this certificate has been director, page 3 should be delached far use as the shauld be filed with the State Dept. af Health priar ta	22c. PHYSICIAN'S FINO MAGI  22d ADDRESS NAME (Type) FINO MAGI  831 Usiv. Blud. E. Silver Spring Ked				
	10Si June 4 UNE ecto auld	230 BURIAL XREMATION 235 DATE THEREOF 234 NAME OF CEMETERY OR CREMATORY 234 10 ATTOM (CITY OF TOWN) (STOTE)				
	TO HOY Page of To FUN direct	Buriol Saight - 1967 adminter hational articipal				
	VR A15 (4) 25M 1/67	24. FUNERAL DIRECTOR  ADDRESS 54 Carries 1 250. RECO BY REGISTRAR 250 REGISTRAR'S SIGNATURE  CED 1 1 1007				
	25M 1/67	Jarchen Wallers. Jakoma Tunerof Home TDATE SEP 11 1967 fellanles Judge				



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12588 12597 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a COUNTY CITY OR TOWN (It outside corporate limits, write, RURAL and, give nearest town) montermen MARYLAND the c. LENGTH OF STAY IN 16 OR JOWN (If outside corporate limits write RURAL and give nearest town) 2 weeks e IS RES DENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADORESS NO X 3 NAME OF Middle DATE Month Year mpletely re carban Dov DECEASED 1967 (Type or print) DEATH SEX 8 DATE OF BIRTH AGE ( n years IF UNDER 1 YEAR IF UNDER 24 HRS 6 COLOR OR RACE 7. MARRIED **NEVER MARRIED** last birthdoy) Months 1834 Doys WIDOWED DIVORCED 10b. KIND OF BUSINESS OR 12 CITIZEN OF WHAT 13 BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) INDUSTRY COUNTRY? Caongin 13. FATHER'S NAMI 14 MOTHER'S MAIDEN NAME ar removal, Thomas Palshaw Alla Hardwick attending parmit. The 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT Jus' and Address Same as Item 2. (Yes, no, or unknown) (If yes give war or dates of service) Lavis I'. Di Justice 1B. CAUSE OF DEATH (Enter only one couse per fine for (o), (b), and (c),) INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (0) Peritonitis DUE TO (h) incarcerated femoral hernia, right Conditions, if any, which gave 1 rise to immediate couse (a), DUE TO stoting the underlying couse 19 WAS AUTOPS!
PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) YES PC NO 200 ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, farm, (City or town) (County) (Stote) factory, street, office bldg., etc.) nt work at work 21. I certify that (I) (this haspital) attended the deceased fram 917 1967 9/26 19 6 / that (I) (we) last ond that death accurred 6/24/673 M, from causes and an the date stated above saw the deceased alive an 220. SIGNATURE 226 PATE SIGNED DIRECTOR M.D director, page Sstantable filed 22d ADDRESS 22c PHYS CIAN'S TO FUNERAL 2-18 W15 Cousin NAME (Type) 230 BURIAL, CREMATION, 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Fown) (County) (Stote) REMOVAL (Specify) Parklaum Cemetory Rockville, an ylan 10-2-67 24 FUNERAL DIRECTOR 250 REC'D BY REGISTRAR TULLIF Y. Bothesda, Marybad 1967 25M 1/67

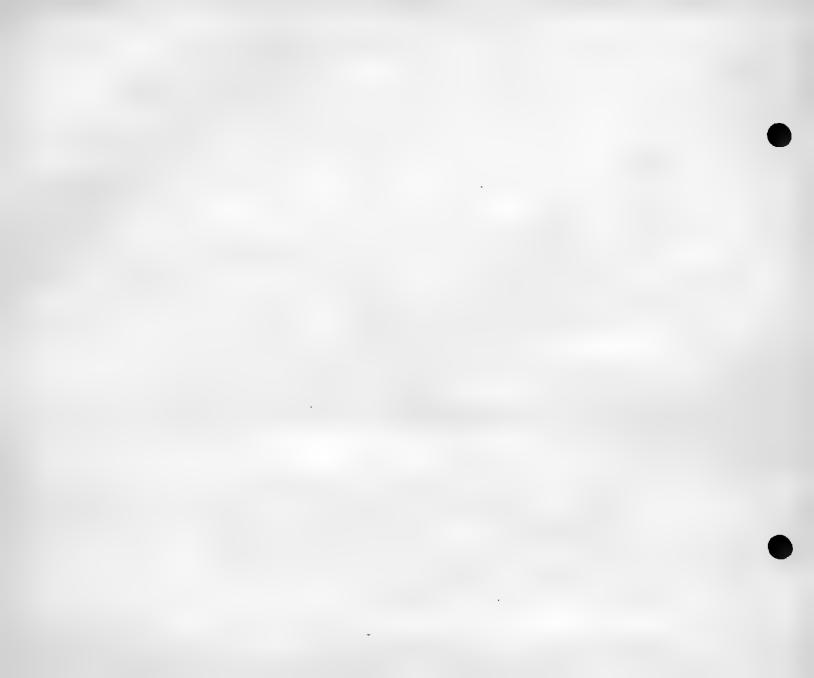
MARYLAND STATE DEPARTMENT OF HEALTH







MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12600 12591 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) Montgomery b. CQUNTY MARYLAND c CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) (If autside corporate limits, c. LENGTH OF STAY IN 1b RURAL and give nearest town) arban papers. Pag nt, wrthin 72 hours a .⊑ INSTITUTION (If nat in haspital, give street address) e IS RES DEN d. STREET ADDRESS ON A FARM filled NO YES (arban NAME OF DATE Year OF DEATH DECEASED 19 (Type or print) SEX 9 AGE (In years) 6. COLOR OR RACE NEVER MARRIED any ev last birthdoy) Months Hours 2-25-88 WIDOWED DIVORCED pub 10a USUAL OCCUPATION (Give kind of work done 1Db KIND OF BUSINESS OR 12 CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) physician c INDUSTRY 15 Con Sin 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME burial, crematian, ar remaval, WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMAT (Yes, no, or unknown) (If yes give war or dotes af service) 220-34-8212 IB. CAUSE OF DEATH (Enter any one cause per line far-(a), (b), and (c).) signed by the burial-transit PART I. DEATH WAS CAUSED BY INSET AND DEA IMMEDIATE CAUSE (a) Page 4 may be retained by the haspital ar attending physician. DUE TO Conditions, if any, which gave rise to immediate cause (a), DUE TO stating the underlying cause be detached far use as the State Dept. of Health priar to DIRECTOR: After this certificate has been PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? NO 20a ACCIDENT WAS UNDERLYING [ 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I ar Part It of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 2Dd INJURY OCCURRED 2De PLACE OF INJURY (Hame, farm, 20c TIME OF INJURY Month, Day, Year 2Df (City or town) (County) (State) MED Hour a.m. factory, street, affice bldg., etc.) Nat While at wark 21. I certify that (1) (this haspital) attended the deceased from director, page 3 should should be filed with the and that death accurred at 13 M, fram kauses and an the date stated above. saw the deceased alive an 22a. SIGNATURE M.D DIRECTOR 22c PHYSICIAN'S 22d. ADDRESS TO FUNERAL KENNETH CRUZE NAME (Type) 230. BURIAL EREMATION 23b. OALZ THEREOF NAME OF CEMETERY OR CREMATORY 23. LOCATION (City of Burn( Charles VR A15 (4



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W, PRESTON STREET, BALTIMORE, MARYLAND 21201 12661 CERTIFICATE OF DEATH Within 72 hours after deoth. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. COUNTY c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) (If outside corporate limits IRAL and give nearest filled in d NAME OF HOSPITAL OR INSTITUTION (If not to hospital, a ve street address) requires that the deoth certificate be executed within NAME OF DATE Month First Dov Year and completely DECEASED event, WIRENCE 19 /2 (Type or print) DEATH IF UNDER 1 YEAR IF UNDER 24 HRS SEX 9 AGE (In years 6 COLOR OR RACE 7. MARRIFD DATE OF BIRTH remove Months DIVORCED burial, cremotion, or removol, and in any 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT 10g JSUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COUNTRY? 14. MOTHER'S MAIDEN NAMI 17 INFORMANT 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dates of service) 402 Clayborn 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c)) INTERVAL BETWEEN ONSEJ AND DEATH signed by the burial-transit p PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) be retained by the hospital or ottending physicion. DUE TO Conditions, if ony, which gove rise to immediate cause (a), DUE TO stating the underlying cause **FUNERAL DIRECTOR:** After this certificate has been director, page 3 should be detached for use as the should be filed with the State Dept. of Health prior to lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? NO YES 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18.) 200 ACCIDENT WAS UNDERLYING [ OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or town) (County) (Stote) factory, street, office bldg , etc.) Hour o.m. Not While at work 21. I certify that (1) (this haspital) attended the deceased fram aug 11 - 194, 1967, to - 196 Z, and that death accurred at 420 M, fram causes and an the date stated above. saw the deceased alive an-22b. DATE SIGNED 220 SIGNATURE DIRECTOR 22d, ADDRESS 22c. PHYSICIANS NAME (Type 23c. NAME OF CEMETERY OR CREMATORY (State) 230. BURIAL, CREMATION 23b. DATE THEREOF 23d. LOCATION (City or Town) (County) REMOVAL (Specify) 9 DATE SEP 18 19 Thomas. VR A15 (4) 20 M 1/66







MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item #9 Film #339: 10/2/57 ph CERTIFICATE OF DEATH 12604 law requires that the death certificate be executed within 24 hours after death. dec funeral PLACE OF DEATH 2 USUAL RESIDENCE (Where deceosed lived, if institution. Residence before odm ssron) o. COUNTY o STATE b county MONTGOMERY ease remove carbon papers. Pages 1 and in any event, within 72 haurs after MARYLAND VIRGINIA b CITY OR TOWN (If outside corporate limits, write RURA, and give nearest jown) c LENGTH OF STAY IN 16 c CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) FAIRFAX BETHESDA 4 days rural .⊑ d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS B IS RES DENCE ON A FARM? filled i 12508 BRADDOCK RD. YES NO [ Naval Hospita 3 NAME OF Middle 4 DATE Lost Month Dov ¥ear DECEASED OF 1967 P FERGUSON SEPT. 19 VADA (Type or print) DEATH IF UNDER 1 YEAR S SEX 6 COLOR OR RACE BATE OF BIRTH AGE ( n years IF UNDER 24 HRS 7 MARRIED NEVER MARRIED 1897 lost b rthday) Months CAUC WIDOWED ± 17 APRIL FEMALE DIVORCED 10o USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12 CITIZEN OF WHAT 11 BIRTHPLACE (County & State, or foreign country) during most of working afe, even if retired) attending physician ( sermit. Then please INDUSTRY COUNTRY? TISA WILKES BARRE, N.C.
14 MOTHER'S MAIDEN NAME HOUSEWIFE 13 FATHER'S NAME burial, crematian, or remayal, LEE PARSONS JULIA CHURCH 17 INFORMANT 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO Address (Yes, no, or unknown) (If yes give wor or dotes of service CHARLOTTE BLEVINS 12508 BRADDOCK RD. FAIRFAX, VA. 18 CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY Pulmonary INTERVAL BETWEEN signed by the burial-transit p ONSET AND DEATH Pulmonary embolus, massive IMMEDIATE CAUSE (o) Page 4 may be retained by the haspital ar attending physician. DUE TO Thrombophlebitis, legs, deep 2 days Conditions, if ony, which gave (b) rise to immediate cause (a). DUE TO stating the underlying couse **TO FUNERAL DIRECTOR:** After this certificate has been director, page 3 should be detached far use as the shauld be filed with the State Dept. af Health priar ta lost PART II OTHER SIGNIFICANT CONDITIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19 WAS AUTOPSY PERFORMED? OR ATTENDING PHYSICIAN: The Diabetes Mellitus NO YES -20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port II of item 18) 200 ACC DENT WAS UNDERLYING [ OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICA, EXAMINER 20c. TIME OF INJURY Month, Dov. Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or fown) (County) (Stote) Hour om Not While of work foctory, street, office bldg, etc.) While ot work 21 I certify that (I) (this haspital) attended the deceased fram 15 SEPT., 1967, to 10 SEPT, 1967, that (I) (we) last saw the deceased alive an 19 SEPT 1087, and that death accurred at 2 p M, fram causes and an the date stated above. 220 SIGNATURE 22b. DATE SIGNED MED DIRECTOR STAFF 20 Sept. 1967 awrence M.D. 22d ADDRESS 22c PHYSICIAN'S NAME (Type) Lawrence W. Raymond, M.D. Naval Hospital, Bethesda, Md. 23c NAME OF CEMETERY OR CREMATORY BURIAL, CREMATION 23b DATE THEREOF 23d LOCATION (City or Town) (County) (Stote) REMOVA (Specify)
BUR LA'L THOMAS BRIDGE CEMETERY MARION 24 FUNERAL DIRECTOR MINUNCORESS 250 VR A15 (4) 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12598 CERTIFICATE OF DEATH 12605 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) & COUNTY Montgomery o. COUNTY o STATE Maryland Montgomery MARYLAND b CITY OR TOWN (If outside corporate amits, C LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write\_RURAL and give\_nearest town) 22 years Silver Spring Silver Spring. d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) remove corbon agpers. d STREET ADDRESS e IS RES DENC ON A FARM? 212 St. Lawrence Drive 212 St. Lawrence Drive NO E YES requires that the death certificate be executed within 3. NAME OF Middle 4 DATE Day Year DECEASED Sept 25 ehry (Type or pant) DEATH 6. COLOR OR RACE 7. MARRIED DATE OF BIRTH AGE ( n years IF UNDER 1 YEAR IF UNDER 24 HRS NEVER MARRIED last birthdoy) Months Doys Hours ond in any WIDOWED DIVORCED Male. plie 10a. USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) **INDUSTRY** COUNTRY? Washington,
14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME burial, cremation, or removal, Mary E. Speiser 17 INFORMANT 16 SOCIAL SECURITY NO Fillins Silver Spring, Maryland (Yes, no, or unknown) (If yes give war or dates of service) 18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gove rise to immediate cause (o). DUE TO stoting the underlying couse ue aerached for use os the State Dept. of Heaith prior to 17/nus last. WAS AUTOPSY PERFORMED? PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) NO X YES 20o ACC DENT WAS LINDER, YING [7] 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Port 11 of item 18.) OR CONTRIBUTING CICAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 2Ge PLACE OF NJURY (Home, form, (City or town) (County) (Stote) Hour o.m foctory, street, office bldg., etc.) Not While 9/25 , 196 Z, that (1) (we) last 21. I certify that (I) (this hospital) attended the deceased fram\_\_\_\_ 7-11 . 19 6 7. ta 1967, and that death occurred of 2337M, from causes and an the date stated above. O FUNERAL DIRECTOR: saw the deceased alive an 220 SIGNATURE 22b. DATE S.GNED director, page 3 stpould be filed v DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S Legnard Gold NAME (Type) 8641 Colesville Rd., Silver Spring, Md 230 BURIAL, CREMATION 23b. DATE THEREO! 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (Stote) Burial Specify) Fort Lincoln Cemetery Prince George Co. Md. Sept. 2So REC'D BY REGISTRAR Cortin 8434 APPESraia Avenue 2Sb REGISTRAR S SIGNATURE VR A15 (4) Silver Spring. DATE CEP



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12597 12606 CERTIFICATE OF DEATH O HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admissional o. COUNTY n. STATE b. COUNTY Montgomery Washington, D.C. MARYLAND b. CITY OR TOWN (If autside carparate limits, c LENGTH OF STAY IN 16 c CITY OR TOWN (If autside carparate limits, write RURAL and give negrest tawn) write RURAL and give nearest tawn) Silver Spring e remove technical filled in er remove technical papers. .= d NAME OF HOSPITAL OR INSTITUT ON (If not in hospital, give street address) e IS RESIDENCE ON A FARM? d. STREET ADDRESS Colonial Villa Nursing Home 807 Butternut Street. N.W. YES □ NO 5c NAME OF Middle 4 DATE OF Last Month Day Year DECEASED Sept. **Ellen** Edith Firor 12 1067 event) (Type or print) DEATH IF UNDER 24 HRS 6. COLOR OR RACE 9 AGE (In years IF JMDER 1 YEAR 7. MARRIED 8. DATE OF BIRTH **NEVER MARRIED** birthday) Manths Days ond in ony June 6, 1880 Female White WIDOWED DIVORCED 10a, USUAL OCCUPATION (Give kind of work dane 10b, KIND OF BUSINESS OR 31. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if refired) pleose INDUSTRY COUNTRY? physician Belvedere, New Jersey U.S. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME or removol. LITZENBERGER James Bittenbender Agnes - Pitter bender 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT 15. WAS DECEASED EVER IN U.S. AKMED PONCES:
(Yes, na, ar unknawn) (If yes give war ar dates af service) 320-03-2028-B Address permit. Patient's Chart buriol, crematian, 18. CAUSE OF DEATH (Enter only one cause per line for (gf), (b), and (c).) INTERVAL BETWEEN burial-tronsit PART I DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (0) Page 4 may be retained by the hospital or ottending physician. signed by DHE-TO Conditions, if any, which gove (b) rise ta immediate cause (a). DUE TO stating the underlying cause prior to l been as the last RMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? has PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH-BUT-NOT CERTIFICATION NO YES ficate j 20g ACCIDENT WAS JNDERLYING 20b, DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 11 of Item 18) OR CONTRIBUTING CAUSE OF DEATH certif detoched (IF EITHER, NOTIFY MEDICAL EXAMINER 20e PLACE OF INJURY (Home, farm, 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED (City or town) (County) (State) Haur 'a.m. Nat While factory, street, office bldg., etc \ at work at work 21. 1 certify that (1) (this hospital) attended the deceased from. 19/(-, /that (1) (we) last director, page a successful died with the , and that death occurred at DIRECTOR: saw the deceased alive an A. M. from causes and on the date stated above. 22a. SIGNATURE DATE SIGNED M.D DIRECTOR 31 U 22c. PHYSICIAN'S FUNERAL NAME (Type) 23a BURIAL CREMATION 23b DATE THEREO (County (Stote) PSMOVAL (Specify) 1 8 196 A24. FUNERAL DIRECTOL VR A15 (4) 25M 1/67



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12598 12607 MEDICAL EXAMINER'S CERTIFICATE OF DEATH PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived | f institution | Residence before odmission) Maryland Rd b COUNTY o. COUNTY Montgomery 9 MARYLAND lionts. C LENGTH OF STAY IN 16 c C TY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b CITY OR TOWN (If outside corporate limits, pup write RURAL and give nearest town) Rockville.Md. Germantown d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) B IS RES DENCE d STREET ADDRESS form f 11100 Ralston Road The Marylander NO IX in Item 18 Give Poges. This certificate should be executed within 24 hours after death NAME OF OECEASEO (Type or print) First Middle 4 DATE Month Day Year KATTE FOOTE Sept. OFATH IF UNDER 24 HRS S SEX 6 COLOR OR RACE 8 DATE OF BIRTH 9 AGE { n yeors 7 MARR ED NEVER MARR ED lost bethdoy) Feb. 26,1881 Female White within 72 hours after death. W DOWED IT. 11 BIRTHPLACE (State or fore gn country) 100 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 106 KIND OF BUSINESS OR 12 CITIZEN OF WHAT INDUSTRY Home Conway . S. C. COUNTRY ? 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME Emma O'Gilrie James O'Gilrie 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO R.H. Mitchell Address Ralston Rd. Rockville, Md. icote, writing the word 'pending' i be farworded to the Chief Medical (Yes, no, or unknown) (If yes give wor or dates of service 12-54-732] 18. CAUSE OF OEATH (Enter only one couse per line for (o), (b), ond (c) PART DEATH WAS CAUSED BY. INTERVAL BETWEEN coronary Insufficency Acute AND DEATH and in ony event IMMEDIATE CAUSE (o) DUE TO Cardio Vascular Disease. years Conditions, if only, which gove rise to immediate couse (a), DUE TO stating the underlying couse PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(c) 9 WAS AUTOPSY PERFORMED? cremotion, or removal, CERTIFICATION NO A 200 EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of tem 18) 3 should PRIMARY I or CONTRIBUTING I 4 should **CAUSE OF DEATH** 20c T ME OF INJURY Month, Doy, Year Hour o.m. 20d INJURY OCCURRED 20e PLACE OF INJURY (Home form 20E (City or town) (County) (Stote) Not While factory, street, office bidg, etc.) FUNERAL DIRECTOR: Poge Ingury (X) 21. I certify that I took charge of the remains described above, held an Autopsy Inspection . and in my opinion Natural causes A. Accident Suicide Homicide death resulted from: Undetermined monner be retoined CHIEF MEDICAL EXAMINER Health prior to ACTUAL 22. OATE SIGNED ASS STANT MED CAL EXAMINER 9-1-67 SIGNATURE the funerol DEPUTY MEDICAL EXAMINER G. Address (Street, cty, town or county) Bethesda. Md. NAME (Type) 23b DATE THEREOF 23d LOCATION of ty or Town) 23c NAME OF CEMETERY OR CREMATORY ((ounty) 0 B世代生智里 Transit 9/1/ 67 Cedar Grove Cem. New Bern. North Carolina 250 RELD BY REGISTRAR 24 FUNERAL DIRECTOR 256 REGISTRAR S SIGNATURE menter Judge VR A 15ME (5) Bethesda, Md. Pumphrey

MARYLAND STATE DEPARTMENT OF HEALTH



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EVAMINED'S CEDTIFICATE OF DEATH

12608

ш	MEDICAL EXAMINER 3	CERTIFICATE OF DEATH					
į	PLACE OF DEATH  O COUNTY - MONTGONICIY  MARYIAND	2 USUAL RESIDENCE (Where deceased lived if institution Residence o STATE	ce before admission)				
_	MARYLAND		, , , , , , , , , , , , , , , , , , , ,				
	b CITY OR TOWN (If autside corporate limits   c LENGTH OF STAY IN 1b write RURAL and give nearest town)	c CITY OR TOWN (If outside corporate him to write RURAL and give	e nearest tawn)				
L	Chery Chose. Years.	Chevel Chase	- 1 1				
	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS	e IS RES DENCE ON A FARM?				
L	7208 Brennon Lene.	1208 + Drennon Lan	e_ YES NO [				
3	NAME OF First Middle	Loss DATE Month	Day Year				
	(Type or pant)	THE DEATH OF EATH	271961				
S	SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED	8 DATE OF BIRTH 9 AGE (Ir years IF JNDER lost butting) Months	Doys Hours Min				
5	entle white WIDOWED   DIVORCED	12/3/96 70 YIS	Doys Hours Min				
jo ja	USUAL OCCUPATION (Give kind of work done industrial ind	11 BIRTHP.ACE (Stote or foreign country)  12 CIT CO'	UNTRY? SA				
I.	FATHER'S NAME ERIC LUNSELL	14 MOTHER'S MAIDEN NAME WILL IS US IN D JOIN	usoN				
	WAS DECEASED EVER IN U.S. ARMED FORCES?  16. SOCIAL SECURITY NO  17.  17.  18. SOCIAL SECURITY NO  18. SOCIAL SECURITY NO  19.	INFORMANT FOR BUSH JEOS A	BRENNYS.				
	18 CAUSE OF DEATH (Enter only one couse per ne for (o), (b), and (c))		INTERVAL BETWEEN				
	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Carcinomatosis		ONSET AND DEATH				
	170 X DUE TO		1/20 513				
	Conditions, if any, which gove ) (b) Adenecarcinoma. ]	eft breast	YEDIS -				
	nse to immediate couse (a), stating the underlying couse DUE TO						
	lost (t)						
CERTIFICATION	PART II OTHER SIGN FICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO	THE TERMINAL DISEASE CONDITION G VEN IN PART I(0)	19 WAS AUTOPSY PERFORMED? YES X NO				
	20a EXTERNAL CAUSE WAS PRIMARY □ or CONTRIBUTING □ CAUSE OF DEATH	(Enter nature of injury in Port I or Part II af item 18.)	barret Issued				
MEDICAL		ACE OF INJURY (Home, form, 201 (City at town) (Cou tory, street, office bldg , etc.)	unity) (State)				
	21 I certify that , took charge of the remains described above, held an Autapsy 🔊 Inspection 🔼 Inquiry 🔀 and in my apinion						
	death resulted from Natural causes 10, Accident 11, Suicide 11, Hamicide 11, Undetermined manner						
	1	CHIEF MEDICAL EXAMINER					
	SIGNATURE Oshn S. Ball	M.D. ASSISTANT MEDICAL EXAMINER	22. DATE SIGNED				
П	EXAMINER'S	DEPUTY MED CAL EXAM NER Z 9/28/6"	7				
	NAME (Type)	Address (Street, city, town, or county)	*				
2:	BURAL (REMATION, 23b DATE THEREOF 23c NAME OF CEMETERY OF	CREMATORY 23d LOCATION (Cty or Town)	(County) (State)				
	FUNERAL DIRECTOR ADDRESS	250 REC'D BY REGISTRAR 25b REGISTRAR'S S	IGNATURE				
	LEE FUNERALITORE 300 40	TWINGET 2 1967 Scharle	o moge				

VR A15ME (5) 6M 1/67

the funeral arrector. Page 4 shauld be farwarded to the Chief Medical Examiner's Office along with form PM3. Page

necessary, please execute the certificate, writing the word

TO DEPUTY MEDICAL EXAMINER:

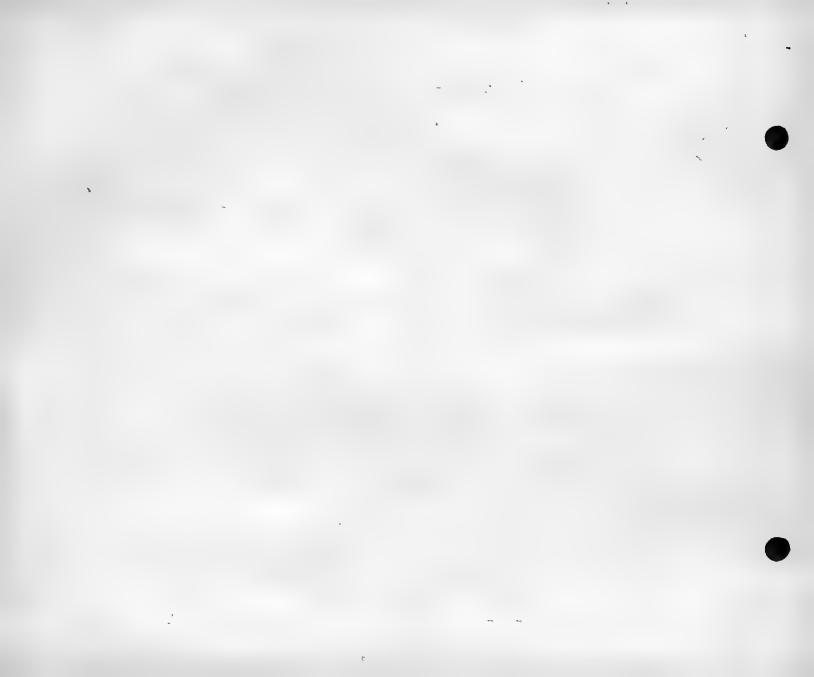
5 may be retained for your files. Health prior to burial, cremation, or removal, and in any event within 72 hours of

This cert ficate shauld be executed within 24 haurs after death. If any delay is rate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to

land 2 with the State Department of



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12609 CERTIFICATE OF DEATH 12600 PLACE OF OEATH 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before adprission) a. COUNTY o. STATE b. COUNTY C LEMETH OF STAY IN 16 b CITY OR TOWN (If autside corparate limits c CITY OR TOWN (If outside coregrate limits, write RURAL and give negrest tawn) write RURAL and give addrest town) PHYSICIAN: The law requires that the death certificate be executed within 24 hours e IS RESIDENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET\_ADDRESS NO 🖂 NAME OF Middle DATE Year corbon DECEASED OF OEATH (Type or print) IF UNDER IF JINDER 24 HRS 7 MARRIED OATE OF BIRTH NEVER MARRIED Months Hours Oavs in any WIDOWED DIVORCED 10a. USJAL OCCUPATION (Give kind of work done 12 CITIZEN OF WHAT 10b KIND OF BUSINESS OR 11. BIRIHPLACE (County & State, or Joreign country) during most of working life, even if retired) COUNTRY? puo 13. FATHER'S NAME MOTHER'S MAIDEN NAME 17. INFORMANT 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, ng. ar yaknawa) (If yes give war ar dates of service) b PART 1 DEATH WAS CAUSED BY: INTERVAL BETWEEN burial-transit ONSET AND CEATH IMMEDIATE (AUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave (b) nse ta immediate cause (a), DUE TO stating the underlying cause WAS AUTOPS)
PERFORMEO? this certificate hos PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO CEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) YES TAL NO 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Part I ar Part II af item 18) 20a ACC DENT WAS UNDERLYING [ OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (State) TIME OF INJURY Month, Oay, Year factory, street, affice bldg , etc ) Nat While OR ATTENDING O FUNERAL DIRECTOR: After 21. I certify that (I) (this hospital), attended the deceased from 196 / that (1) (we) las 1967 and that death occurred of 250 M, from couses and on the date stated above sow the deceased alive on \_\_\_\_\_\_ 22g SIGNATURE MED DIRECTOR director, page 3 should be filed v M.D. PHYS PHYS 22d ADDRESS 22c. PHYSICIAN'S TO HOSPITAL MOBERT JAO. NAME (Type) 4429 23d LOCATION (City or Town) 230 BURIAL CREMATION 236 DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY (Condity) (Stote) REMOVAL (Specify) 10T Cedar Hill Suitland 9-20-67 Crematory Maryland 24 FUNERAL DIRECTOR ADDRESS 2So. REC'D BY REGISTRAR 25b REGISTRAR S SIGNATURE VR A15 (4) 25M 1/67 A Pumphret 7557-Hisgonsun Ave



<u></u>	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	
	12601 CERTIFICATE OF DEATH	12610
fer death	1. PLACE OF DEATH a. COUNTY Mortgomery MARYLAND 2. USUAL RESIDENCE (Where deceosed lived, if institution R b. COUNTY Country	Residence before admission) Lorayth
haurs after in by the research	b CITY OR TOWN (If outside corporate limits, write RURAL a write RURAL and survey nearest town)  d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address)  d STREET ADDRESS	e IS RESIDENCE ON A FARM?
campletely filled in ave carboy papers.	3. NAME OF DECEASED (Type or print) Gustaw & Friedenburg OF DEATH DEATH	3 YES NO O
e executed with campletely remave carbo	S. SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED 8 DATE OF BIRTH 9 AGE (In years 15) Mo	UNDER I YEAR IF UNDER 24 HRS. In this Days Hours Min
ficate be ysician ar please n at, and in	1DO USUAL OCCUPAT ON (Give kind of work done during most of working life even if retired)  1Db KIND OF BUSINESS OR UNDUSTRY  13. FATHERS NAME  14. MODULER'S MAIDEN NAME	12 CITIZEN OF WHAT COUNTRY?
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death Page 4 may be retained by the hospital or attending physician.  TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 shauld be detached for use as the burial-transit permit. Then please remave carbop pages. Pages 1 med Should be filed with the State Dept. af Health priar to burial, crematian, or remaval, and in any event, within 72 hours after death	IS WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, accompany nawn) (If yes give war or dates af service)  15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, accompany nawn) (If yes give war or dates af service)	6 608 darras ed.
that the and an.  by the attransit per	IB CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c))  PART I DEATH WAS CAUSED BY.  IMMEDIATE CAUSE (a)  DUE TO  DUE TO	INTERVAL BETWEEN ONSET AND DEATH
bing PHYSICIAN: The law requires the by the hospital or attending physician. Ifter this certificate has been signed by be detached far use as the burial-transtate Dept. af Health priar to burial, cre	(and thions, if any, which gave nse to immediate cause (a), stating the underlying cause (b)  DUE TO  Conomination Atherosclerosis  Atherosclerosis	10 years
N: The law or attend or attend or at has be use as t	PART II OTHER SIGNIFICANT CONDITIONS CONTRICTING TO DEATH R IT NOT PELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	19 WAS AUTOPSY PERFORMED? YES NO
HYSICIAI hospital is certifica ached fai	PRUIDUS COULD VONSUM OCCURRED (Enter nature of injury in Part II of Nem IB.)  20a ACCIDENT WAS UNDERLYING  OR CONTRIBUTING CLAUSE OF DEATH OR CONTRIBUTING CLA	(County) (State)
NDING P and by the After th Id be det	21. I certify that (1) (this hospital) attended the deceased from sent 18. 19 1, to sent 2.	, 1951 , that (1) (we) last
OR ATTEND be retained burector: A ge 3 should	22a. SIGNATURE  M.D. ATTENDING SI MED. STAFF   2  M.D. PHYS.   DIRECTOR   PHYS     2	an the date stated above.  2b. DATE SIGNED  9/23/67
TO HOSPITAL OR A Page 4 may be re director, page 3 s Should be filed with the standard of the	22c. PHYSICIAN'S NAME (Type) STANLEY M. BIALEK 8218 WISCOWS'N AUR. ( 230 BURIAL, CREMATION, 23b. DATE THEREOF 23k, NAME OF CEMETERY OR CREMATORY 23d_LOCATION (CITY OF TOWN)	County) (State)
TO HO A STAN A S	CREMATORY SUITLAND	M A



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12611 FOR STATE HEALTH DEPT. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased aved if institution Residen before admission) a COUNTY Montgomery Marvland Montgomery MARYLAND C LENGTH OF STAY N 1b c CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) b City OR TOWN (If outside corporate limits, e pages 1 and 2 with the State Departme write RURAL and give nearest town)
Silver Spring, Md. DOA Wheaton d NAME OF HOSPITAL OR INSTITUT ON (If not in haspital, give street address) d. STREET ADDRESS e, writing the ward "pending" in pencir in Item 18 Give Pages 1, farwarded to the Chief Medical Examiner's Office along with farm 3027 Holy Cross Hospital Kramer St. NO IXIX This certificate shauld be executed within 24 hours after death Middle Lost 4 DATE DECEASED OF DEATH Furcolow 18, Sept, 67 Marv Rebecca (Type or pant) B DATE OF BIRTH F UNDER 1 YEAR 6. COLOR OR RACE 9 AGE (In years F UNDER 24 HRS 7 MARRIED XX NEVER MARRIED last birtriday) Haurs 11, Feb, 25 Female White within 72 haurs after death WIDOWED DIVORCED 11 BIRTHPLACE (State or foreign country) 10b K ND OF BUSINESS OR 12 CT ZEN OF WHAT 10a USUAL OCCUPATION (Give kind of work dane during mast of warking life, even if retired) Mississippi 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME LeRou Mc Ewen Edris Gilmore IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANI 3027 Kramer Street (Yes, ng, or unknown) (If yes give wor or dates of service) William H 18 CAUSE OF DEATH (Enter only one couse per ONSET AND DEATH and in any event PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gove nse ta immediate cause (a), DUE TO stating the underlying cause PART I OTHER SIGN F CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19 WAS AUTOPS PERFORMEDS cremat an, or removal, CERTIFICATION 20a EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 1 of Item 18) 3 should PRIMARY I or CONTRIBUTING I CAUSE OF DEATH MEDICAL 20f (City or town) 20c TIME OF INJURY Manth, Day Year 20d NJURY OCCURRED 2De PLACE OF INJURY (Hame, form, (County) (State) factory, street, office bldg, etc.) Hour a.m. may be retained far your FUNERAL DIRECTOR: Page 21. I certify that betak charge of the remains described above, held an Autapsy ... Inspection ... and in my opinion Inquiry 2 Natural causes death resulted from Undetermined manner Homicide funeral directar Suic de 22. DATE SIGNED SIGNATURE **EXAMINER'S** NAME (Type) 23d LOCATION (City or BURIA, CREMATION 0 REMOVAL (Specify) netery Silver Spring, Ma 250 REID BY REGISTRAR 256 REGISTRAR'S SIGNAT 1967 Gate of Heaven Cemetery ma 8434 Georgia Ave. VR A15ME (5) DATSEP Silver Spring. Md.



DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201 .

CERTIFICATE OF DEATH 12603 12612 PHYSICIAN: The law requires that the death certificate be executed within 24 hours ofter deoth PLACE OF OEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) b. COUNTY ntgomery o. COUNTY MONTGOMERY MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) Sil. Sprg. Md. c CITY OR TOWN (If autside corporate limits, write RURAL and give nearest towi C. LENGTH OF STAY IN 116 Silver Spring , Maryland 1. hr d. NAME OF HOSPITAL OR INSTITUTION HIS not in hospitol, give street oddress) d STREET ADDRESS IS RESIDENCE ON A FARM? 10721 Meadowhill Road 5 Pm YES NO PK NAME OF Middle Lost 4 DATE Month Opv Year OECFASED
(Type or print) OF OEATH Giebel 9 10 67 H Vernell S. SEX OATE OF BIRTH 9 AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE 7 MARRIED NEVER MARRIED Months 4/27/98 White WIDOWED DIVORCEO 100 USUA: OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working ite, even if retired) COUNTRY? INDUSTRY Kentucky housewife 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME or removal Estes Reynolds IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT (Yes, no, or unknown) (If yes give wor or dates of service) Holy Cross 1500 Forest G. en Rd. SSMd. no cremation, 18 CAUSE OF DEATH (Enter only one couse per one for (o), (b), and (c) PART I. OEATH WAS CAUSED BY INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (o) DUE TO Signed Conditions, if any, which cove rise to immediate cause (o), DUE TO stoting the underlying couse 19 WAS AUTOPSY PERFORMEDS PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO GEATH BUT NOT RELATED TO THE TERMINAL O.SEASE CONDITION GIVEN IN PART 1(g) NO this certificate 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of Item 18.) 20o. ACCIDENT WAS UNDERLYING [ OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL (Cty or town) 2Dc TIME OF NJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF NJURY (Home form, (County) (Stote) foctory, street, office bldg, etc.) al work 21. I certify that (1) (this hospital) attended the deceased fram Aur 1967 to 27 Left 1967, that (1) (we) ias 1947, and that death accurred at 18 A M, fram causes and an the date stated above. FUNERAL DIRECTOR: saw the deceased alive on. 220 SIGNATURE 22b DATE SIGNED Z DIRECTOR PHYS 22d ADDRESS 22c. PHYSICIAN'S NAME (Type) 302-230 BURIAL, CREMATION, 23b. DATE THEREOF (County)

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12613 12604 CERTIFICATE OF DEATH death. death, tuneral PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o. STATE vithin 72 haurs after MARYLAND b CITY OR TOWN (If autside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN autside carparate limits, write RURAL and give nearest town write RURAL and give nearest town) = d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 M ON A FARM? filled i NO D sicion and completely fil obase remave carbon , and in any event, with NAME OF Middle DATE Last Month Day Year DECEASED OF LLEN (Type or print) DEATH 19 6 16more S. SEX AGE (In years IF LINDER 1 YEAR 6 COLOR OR RACE 7. MARRIED Xi DATE OF BIRTH IF LINDER 24 HRS NEVER MARRIED last birthday) Days Hours WIDOWED DIVORCED 16o. USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11 BIRTHPLACE (Lounty & Stote, or foreign country) during mast of warking life, even if reffred physician ( INDUSTRY COUNTRY? 13. FATHER S NAMI 14. MOTHER'S MAIDEN NAME burial-transit permit. Then pi burial, crematian, ar remaval, more 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address (Yes, na, ar unknown) (If yes give war ar dates af service) 18. CAUSE OF DEATH (Enter only one cause per line for of (b), and (c).) INTERVAL BETWEEN signed by the burial-transit PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave nse ta immediate cause (a), DUF TO far use as the t f Health priar ta b stoting the underlying couse has been PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY PERFORMED? NO F YES 🗌 10 FUNERAL DIRECTOR: After this certificate 20g ACCIDENT WAS UNDERLYING 206 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 11 of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) TIME OF INJURY Month, Day, Year 20d INTURY OCCURRED 20e PLACE OF INJURY (Hame, farm (City or fown) ((ounty) (State) Hour am Not While factory, street, affice bldg , etc.) 19 at work 19 67, that (I) (we) las 21. I certify that (1) (this haspital) attended the deceased from 1967 be retained and that death accurred at M, fram causes and an the date stated above saw the deceased alive on. 22o. SIGNATURE 22b DATE SIGNED ATTENDING X DIRECTOR M.D. 22c PHYSICIAN'S 22d ADDRESS TO HOSPITAL DETHESDA MO OLD GEORGETOWN KD NAME (Type) 10461 directar, shauld t BURIAL, CREMATION. 23b DATE THEREOI 23c NAME OF CEMETERY OR CREMATORY 23d-10CATION (City or Town) (State) REMOVAL (Specify). 25m REC'D BY REGISTRAR VR A15 (4) 25M 1/67



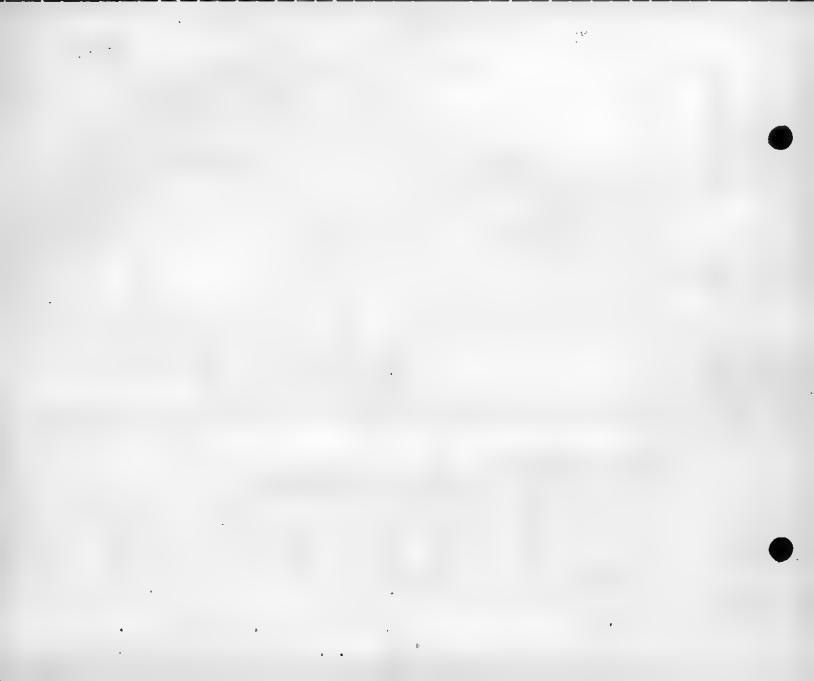
,1	MARYLAND STATE DEPARTMENT OF HEALTH  DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORI	E 1. MARYLAND
N -/	12605 T. "CERTIFICATE, OF DEATH	12614
deart deart	1. PLACE OF DEATH a. COUNTY a. COUNTY b. COUNTY D. STATE DEATH DEA	
	MONTROMERY COUNTY MARYLAND D.C. WISHIT	B BMCRY / ICIO.
hours at line) the line of the	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)  SILVER  SPRING  C. LENGTH OF STAY IN 1b  C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)  SILVER  SPRING	RURAL end give nearest town) Vashington
2 P 2 2 2	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS	th St   e. IS RESIDENCE
2 ± 8'ë	HOLY CROSS HOSPITAL EASTIWEST! THICH WAY	N.W. YOU NO !
icate be executed within physician and completely please remone-carbon, val, and in any/event, with	3. NAME OF DECEASED (Type or print) ISAAC "IKE" GOLDBLATT DEATH SEPT	Day Year /2 19 6 7
com com	5. SEX 6. CDLDR DR RACE 7. MARRIED NEVER MARRIED 8. DATE DF, BIRTH 9. AGE (In years) IF	UNDER 1 YEAR IF UNDER 24 HRS
and any	MITE WIDOWED DIVDREED 1/4/18 89 Vrs.	onths Days Hours Min.
	10a. USUAL OCCUPATION (Give kind of work done lob. KIND OF BUSINESS DR during most of working life, even if retired)  11. BIRT HPLACE (County & State, or foreign country)	12. CITIZEN DF WHAT CDUNTRY?
ate l Mysic plea al, an	MOTION PICTURES PERATER PICTURES FUSTRIA  13. FATHER'S NAME  14. MOTHER'S MAIDEN NAME	7915-B.
that the death certificate be sician. ned by the attending physician al-transit mermit. Then pleasmal, cremation, or removal, and i	MAX JOCOB COLOBIATE LIHATION M	
th ce ttemd nit. or re	15. WAS DECEASED EVER IN U.S. ARMED FORCES?   16. SOCIAL SECURITY ND.   17. INFORMANT Address (Yes, ng, or unkown)   (If yes give war or dates of service)	6101-86-ch
deat le at lerrion,	10 - 053-34.9084 MAX J. COLDBLATT SOIT	STIM, W.
mater he	PART I. DEATH WAS CAUSED BY:	INTERVAL BETWEEN DNSET AND DEATH
The law requires that the or attending physician. sate has been signed by the use as the burial-transit saith prior to burial, cremaint	OUE TO	
res phys phys sig buris buris	Conditions, if eny, which gave rise to immediate (b) Centered Selection Server	gul.
requires that ding physicia been signed the burial-tr or to burial, c	cause (a), stating the DUE TD	
law re tittendi has bi as as th	underlying cause last.	RT1(e)   19. WAS AUTDPSY
t: The la al or at ificate h for use Health	Arter trountine Le (2) hele.	PERFORMED?
CLAN: The ospital or a certificate hed for use hed for use to the alth	PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. DTHER SIGNIFICANT CONTRIBUTION GIVEN II. DTHER SIGNIFICANT CONTRIBUTION GIVEN IN PART II. DTHER SIGNIFICANT CONTRIBUTION GIVEN IN PART II. DTHER SIGNIFICANT CONTRIBUTION GIVEN IN PART II. DTHER SIGNIFICANT CONTRIBUTION GIVEN GI	tem 18.)
PHYSICIAN the hospital this certion detached fite Dept. of		
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the Page 4 may be retained by the hospital or attending physician. FINERAL DINEITOR: After this certificate has been signed by director, page 3 should be detached for use as the burial-trum should be filed with the State Dept. of Health prior to burial, cre-	20c. TIME OF INJURY Month, Day, Year   20d. INJURY OCCURRED   20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)    Hour e.m.   While   Not While   factory, street, office bldg., etc.)	(County) (State)
NDIN ned I	21. I certify that (I) (this heepital) attended the deceased from 8/20/6719 to 9//2	, 1965 that (I) two last
A ATTENDI P. retained IETTOR, A 3 should with the	saw the deceased alive on 9/1/19 6 2 and that death occurred at 7/2/4/5/om the causes an	nd on the date stated above. 22b. DATE SIGNED
AL OR nay be page 3 filed w	Day Je Chanku D.O. ATTENDING MED. STAFF DIRECTOR PHYS.	9/12//
ITAL may RILL r, pa	22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS	
O HOSPITAL Page 4 may II FIINERIL director, pa	23a. BURIAL, GREMATION, 23b. DATE THEREDF   23c. NAME DF CEMETERY DR CREMATORY   23d. LOCATION (City, town	n or county) (State)
5 E &	BURIAL (Specify) 9/13/67 UNION FIELDS & ETT OFFEINS	14,7
	22. FUNERAL DIRECTOR 258. REC'D BY REGISTRAR 256. REG	ISTRAR'S SIGNATURE
VR AI5 (4) 20M 1/65	GOLDBERG FORTERIAL HORE CTIMILL DATSEP 14 1961	



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12500 CERTIFICATE OF DEATH 12615 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) PLACE OF DEATH a. COUNTYM a. STATE b. COUNTY MARYI AND MONTOCHERU The law requires that the death certificate be electrical within 24 hours after b. CITY OR TOWN (If ayride carparate mays, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If apxide carparate limits, write RURAL and give nearest flown) ENSINATO d. STREET ADDRESS e 15 RESIDENC d NAME OF HOSPITA. OR INSTITUTION (If not in hospital, give syeet address) ON A FARM 5303.38 YES NO 🖂 VANITERIUM NAME OF DATE Middle Last Day Year DECEASED (Type or print) OF DEATH 110 19 6 S SEX 9. AGE (In years IF UNDER 1 YEAR F JNDER 244 RS 6. COLOR OR RACE DATE OF BIRTH 7. MARRIED NEVER MARRIED 9 last birthday) Manths Davs Haurs WIDOWED 5 DIVORCED and in any pillo 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT YI, BIRTHPLACE (County & State, or fareign country) physician a Ien please during most of working life, even if retired) **COUNTRY?** INDUSTRY land HOUSE WI 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME burial, crematian, ar remaval, DORSEY THOMAS 17 INFORMANT IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. (Yes, na, or unknown) (If yes give wor or dates of service 13-09- 8399 6X INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). burial-transit PART I. DEATH WAS CAUSED BY. ONSEY AND DEATH signed by by the haspital ar attending physician. 4200 DHE TO Conditions, if ony, which gave " rise to immediate cause (a), DUE TO stating the underlying cause State Dept. of Health prior to last 0.5 WAS AUTOPSY PERFORMED? has PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO 🖂 ficate ġ 20o ACC DENT WAS UNDERLYING □ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port 1 or Part 11 of item 1B) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20d INJURY OCCURRED 20c. TIME OF INJURY Month, Day, Year Hour o.m factory, street, office bldg., etc.) Not While ot wark at wark TE HOSPITAL OR ATTENDIN Page 4 may be retained by TO FUNERAL DIRECTOR: Afr 21. I certify that (1) (this haspital) attended the deceased fram Wall 19 65 10 196 7 that (1) (we) last 19 67, and that death accurred a 30 M, fram causes and an the date stated above. saw the deceased dive on 22a, SIGNATUR 22b DATE SIGNED ATTENDING directar, page 3 shauld be filed v M.D. DIRECTOR PHYS PHYS 22d ADDRESS 7852 22c. PHYSICIAN'S NAME (Type) 23c. NAME OF CEMPTERY OR CREMATORY 23d LOCATION (City or Town) 23b DATE THEREO! (County) (State) 230 BURIAL CREMATION Sept 5, 1967 Friendship Cemetery Friendship Md REMOVA (Specify) 0 2Sb. REGISTRAR'S SIGNATURE ADDRESS 2Sa. REC'D BY REGISTRAR 24 FUNERAL DIRECTOR Milayles F. Gasch's Sons Hyattsville, Md. VR A15 (4) 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12607 CERTIFICATE OF DEATH 12616 after death 2 USHAL RESIDENCE (Where deceased lived if institution. Residence before admission) PLACE OF DEATH o. COUNTY o. STATE b. COUNTY MARYLAND Washinoton, D.C. Montoomery b CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) c LENGTH DE STAY IN 16 c. CITY OR TOWN (if outside corporate limits, write RURAL and give negrest town) requires that the death certificate be executed within 2/ hours 1 month e IS RESIDENCE ON A FARM? d. NAME OF HOSP TAL OR INSTITUTION (If not in hospital give street address) d STREET ADDRESS physician and completely, filled in en please remave/carban papers. 517 Buchanan St., NW YES NO × University Nursing Home corbon erft-vert 3 NAME OF Middle Last 4 DATE Month Day Year DECEASED William Thomas Green 5 (Type or print) 19 6 27 DEATH IF UNDER 24 HRS. S SEX 6 COLOR OR RACE B. DATE OF BIRTH 9. AGE (In years IF JNDER 1 YEAR 7. MARRIED **NEVER MARRIED** last birthday) Days Hours WIDOWED DIVORCED 11/3/1900 Male Negro 10a USUAL OCCUPAT ON (Give kind of work done 10b KIND OF BUSINESS OR 32. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or fareign country) during most of working life, even if retired) COUNTRY? INDUSTRY Minister 13. FATHERS NAME Washington, DC 14. MOTHER'S MAIDEN NAME HSA the attending phy sit permit. Then Hirknown Ada Green 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address Wash. (Yes, na, ar unknown) (If yes give wor or dates of service) Mrs. Wm. Green-517 Buchanan St., NW. INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c)) burial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) signed by DUE TO Canditians, if any, which gave nse to immediate cause (o), DUE TO ed far use as the back af Health priar to b stating the underlying cause the hospital ar attending O FUNERAL DIRECTOR: After this certificate has been 19 WAS AUTOPS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) CERTIFICATION PERFORMED? YES T NO 20g. ACCIDENT WAS UNDERLYING [ ROS. DESCRIBE FOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item IB.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f (City or town) (County) (Stote) TIME OF INJURY Month, Doy, Year factory, street, affice bldg., etc.) Not While at wark 21. I certify that (I) (this haspital) attended the deceased from and that death accurred at RAM M, fram causes and an the date stated above 196 sow the deceased alive on 22a SIGNATURE 22b. DATE SIGNED ATTENDING DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Russell, Bufalino/ 1429 University Blvd., West M.D. Md. director, shauld b 23a. BURIAL CREMATION 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) - REMOVAL (Specify) Memorial Pk. Inndover Harmony 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR Jenkins ARO1 Ga Ave N.W. Johnson 1967 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12508

CERTIFICATE OF DEATH

12617

1	PLACE OF DEATH			2. USUAL RESIDENCE	(Where deceosed aved, if anstitu-	t an: Residence be	efare admission)
	o. COUNTY	D	MARYLAND	o. STATE	+ of Columb,		1
	b CITY OR TOWN (If outside	e cornorete limits	c LENGTH OF STAY IN 16		jutside corporate fimits, write RU		grast town)
	write RURAL and give ne	earest tawn)	C CENOTIL OF STATE OF THE	C CIT OK IONN (II U	latsiae calparate illitis, wille ko	ME and dies use	HEN IOMII)
	Takoma P	ark	1 day	indeplui	nation		4
	d. NAME OF HOSPITAL OR IN	ISTITETION (If not in hospital,	give street address)	d. STREET ADDRESS	9		e IS RESIDENCE ON A FARM?
	Washingt	on Hospital.	+ Sanitarium	1414 Nich	alson Street	N.W.	YES NO
3,	NAME OF DECEASED	First	Middle	Last	4 DATE Man		Day Year
-	(Type or print)	1/20mas	W. (ZXXX)	Sriffin	DEATH Scote	wper	1 19 67
١.	SEX 6. COL	OR OR RACE 7. MARRIED	NEVER MARRIED	Tebo B85,1	.877 9. AGE (In years	Months Day	
~	male wi	wit c WIDOWED	DIVORCED	XXXXXX	90\ Y5	I Months Day	ys 11dors Mar.
10	a JSUAL OCCUPATION (Give k		KIND OF BUSINESS OR	11 BIRTHPLACE (County	y & State, or fareign country)	12 CIT-ZEN	
	iring most of working life, even		NDUSTRY	Dick 4.	of Columbia	COUNTR	"A.
	3. FATHER 5 NAME	1000		14. MOTHER'S MAIDEN	NAME -		
	Thomas	Criffin		Mary	Mulkerin		
13	WAS DECEASED EVER IN U.S.	ARMED EORCES2 16	SOCIAL SECURITY NO 17	Williams R	Griffin	ess 517.	verSpring
()	res, no or unknown) (If yes gi	ve war or dates at service)	78-36-2863A	Jegiveno e	~~ 11405 N		
F				TEONEON C	-VOILTTAOD IN		INTERVAL BETWEEN
П	PART I. DEATH WAS	ter anly one cause per une fo CAJSED BY.	or (a), (b), and (c) )	- 4			ONSET AND DEATH
Н		MMEDIATE CAUSE (a)	ocel m	ge			
		DUE TO	. 0	1 111	, ,		5 years
П	Canditions, if any, which g		mastere	brenchit.	3 Temphys	ema.	1 4
П	stating the underlying co				/ /		
ш	lost.	(c)			·		
1	PART II OTHER SIGNIFICAN	IT CONDITIONS CONTRIBUTING	TO DEATH BUT NOT RELATED TO	THE TERMINAL DISEASE CO	INDITION GIVEN IN PART 1(a)		19 WAS AUTOPSY
CERTIFICATION							PERFORMED?
2	200 ACCIDENT WAS UNDERL	VINCET 1 206 I	ACCOUNT HOW INTUNA OCCUPANT	/Fatar mature of lawrence	Don't Law Dank H. of Jan. 101		YES NO
	OR CONTRIBUTING CAUSE		PESCRIBE HOW INJURY OCCURRED	fruier indiate at indoxy in	Pari Far Pari II or Item 16 )		
		,					
MEDICAL	20c TIME OF INJURY Mon			ACE OF INJURY (Hame, for ctary, street, affice bldg , etc		(Caunty)	(State)
18	p.m.	19 While		ciary, street, affice blay, etc	1		
	21. I certify that	(I) (this hospital) atte	ded the deceased from	1952	19 to Jeht 1	1967	that (I) (we) las
	saw the deceases	1 /7			2.15 /M, from couses		
	220 SIGNATURE	1			/	22b DAJE SI	
	1	Sil IXlvar	grean A	D PHYS	MED STAFF	] Sext	,
	22c PHYSICIAN'S	2007.00	171	D PHYS 22d. ADDRESS	DIRECTOR L PHYS L	1 00/1	1,11-/
		hilip Bloen	ng m o		onn. Ave. Ch	orre Ch	162
						evy Ch	
	BURIAL, CREMATION, RINGOVAL (Specify)	23b. OATE THEREOF	23c. NAME OF CEMETERY OR		23d LOCATION (City or To	,	
	AND THE PROPERTY OF THE PROPER	9/4/67	Prospect Hingtonesis D.C.	111 Comete	ry Washing	ton & I	D.G.
7	4 FUNERAL DIRECTOR	wash:	natowers D.C.	N.W. 250 REC	D BT REGISTRAR	EGIŞİRAR'S SIĞNA	TURE
T	ocenh Gara	anda Sana F	130 111 40000	DATE DATE	1 1301 1	Marie	1

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the haspital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complication, page 3 should be detached far use as the burial-transit permit. Then please remavely should be filed with the State Dept. at Health priar ta burial, crematian, at remaval, and in any ever VR A15 (4) 25M 1/67

filled in by



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 2618 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, It institution: Residence before admission) a. CDUNTY b. COUNTY-Montgomery Maryland Hontgomery MARYLAND CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b Kensington Kenging ton vears e. IS RESIDENCE d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS DN A FARM? 9900 Spring Road 9900 Cld Spring ND1 YES law requires that the death certificate be executed within NAME DE DATE Month Day Year Middle Last DECEASED DEATH September 1967 (Type or print) eve 6. COLOR DR RACE 7. MARRIED NEVER MARRIED 5. SEX DATE OF BIRTH AGE On years | IF UNDER 1 YEAR | IF UNDER 24 HRS 8. 9. last birthday) Months Hours Jan. Female White WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN DF WHAT COUNTRY? S. Haushuife Washi no ton. 13. FATHER'S NAME 14. MDTHER'S MAIDEN NAME James L. Giles Nettie B. Nicholson Address 15. WAS DECEASED EVER IN U.S. ARMED FDRCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknwn) (If yes give war or dates of service) Same 85 Item 2. Diller B. Groff. INTERVAL BETWEEN ONSET AND DEATH 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). l-transi PART I. DEATH WAS CAUSED BY: hospital or attending physician. 24.00 IMMEDIATE CAUSE (a) burial-tr burial, DUE TO Dissecting Aortic a mont Conditions, If any, which (b) peen rise to Immediate 활유 DUE TO cause (a), stating underlying cause last, Se CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTDPSY for use Health PERFORMED? certificate ND: YES PHYSICIAN: 20a. ACCIDENT WAS UNDERLYING [] DR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) detached f MEDICAL (State) (County) 2Dc. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) factory, street, office bldg., etc.) be de State Hour a.m. Not While While ATTENDING at work at work p.m. 19 DIRECTOR: Af 1966 to 21. I certify that (I) (this hospital) attended the deceased from and that death occurred at 700AM, from the causes and on the date stated above. saw the deceased alive Dn\_ 196 22b. DATE SIGNED 22a. SIGNATURE MED. DIRECTOR fled M.D. 逗 HOSPITAL 22d. ADDRES FUNERAL 22c. PHYSICIAN'S lirector, p NAME (Type) (State) CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) 23b. DATE THEREOF BURIAL, CREMATION. 0 8 REMOVAL (Specify) Grematory. remation REC'D BY REGISTRAR 25b. 24. FUNERAL DIRECTOR 1967 Bethesda, Maryland VR A15 (4) 20M 1/65



<i>a</i>	MARYLAND STATE DEPARTMENT OF HEALTH
	DIVISION OF VITAL RECORDS, 301 W. PRESTON, STREET, BALTIMORE, MARYLAND 21201
FOR STATE	126 V MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12619
HEALTH DERT.	1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) 5. COUNTY 6. COUNTY 7. STATE 8. COUNTY 8. COUNTY 9.
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	d NAME OF HOSPITAL OR INSTITUTION (f not up to spiro, give street oddress)  d. STREET ADDRESS F. Liting and A TOTAL OF IS RESIDENCE
orm orm	d NAME OF HOSPITAL OR INSTITUTION (I not up to spite) give street oddress)  d. STREET ADDRESS 5 Wisconsin Average on A FARM?  VES NO. 19
Pages with farr	3. NAME OF First Middle Lost 4 DATE Month Doy Year
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24 ha n Iter 's Off s lan fter d	during most of working life even if retired)  INDUSTRY  LIE ACC (Side of Total Control Country)  COUNTRY S.
thin 24 miner's pages urs afte	13. FATHER'S NAME  Hymother's Malden NAME  HEBECCA Pielule
d with per I Exam File (	15. WASDECEASED EVER N. U.S. ARMED FORCES? 16 SOCIAL ACCURITY NO 17 INFORMANT
ecute Jing' edica ermit	(Yes, ny of unknown) (If yes give wor or dotes of service) 215-54-stap 2015 A 250
e shauld be executed within 24 haurs the ward "pending" in pencii in Item 18 ta the Chief Medical Examiner's Office of burial-transit permit F1e pages 1 and 2 vin any event within 72 haurs after death	18 CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a)  TRIERVAL BETWEEN DRSET AND DEATH
auld ward he Ct iral-tra	Conditions if any which save a
This certificate should be executed within 24 hours after death. If a cate, writing the ward "pending" in pencii in Item 18. Give Pages 1, be farwarded to the Chief Medical Examiner's Office along with farm 1 be used as a burial-transit permit. File pages land? with-thestate Degremayal, and in any event within 72 hours after death	rise to immediate cause (a).  stating the underlying cause  DUE TO
rithcate riting triting traced varded as a ged as a ged and it an	lost.   (c)   (c)
This certificate, writh the farwant be used or emayal,	Ze are PERFORMED? YES NO
# - C -	PRIMARY 🗆 or CONTRIBUTING 🗆 CAUSE OF DEATH
AL EXAMINER: execute the cert r. Page 4 shault far yaur files. for: Page 3 shaural, cemation, o	20c. TIME OF INJURY Month, Doy, Yeor Hour o.m.  p.m. 19  20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form foctory, street, office bidg., etc.)  Yhile of work of work
AL EXA Execute Tr. Page I far yau TOR: Page r al, crem	21. I certify that I taak charge of the remains described above, held an Autapsy 🔲, Inspection 🔀, Inquiry 🔲, and in my apinion
se ex ctor. ned f	death resulted fram: Natural causes Accident , Suicide , Hamicide , Undefermined manner
MEDIA please Il directo retaine L DIREC	ACTUAL SIGNATURE ASSISTANT MEDICAL EXAMINER 22. DATE SIGNED
necessary, please execute the funeral director. Page 4 5 may be retained far yaur o runeral DIRECTOR: Page Health priar to bural, crema	DEPUTY MEDICAL EXAMINER AND AME (Type)
nece the to no control to the to the to the	230 EDRIAL, CREMATION, 23b. DATE THEREOF 23 NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (Stole)
VR A15ME (5) 6M 1/67	24 FUNERAL DIRECTOR  COLORDON FUNELAL/HOME 4217 904 ST. N. W. DATE SEP 13 1507 FUNELAL/HOME 4217 904 ST. N. W.



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12811 CERTIFICATE OF DEATH 12620 death. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. COUNTY o. STATE The law requires that the death certificate be executed within 24 hours after, within 72 hours after b. CITY OR TOWN IN c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRES filled NAME OF DATE and completely DECEASED OF DEATH (Type or pnnt) eve SEX AGE (In years lost birthday) MARRIED NEVER MARRIED Days WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12 CIT ZEN OF WHA during most at working life, even if refired) INDUSTRY COUNTRY? Ture Insurance 13. FATHER'S NAME S. Haight Henry 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address Same as Item 2 (Yes, no, or unknown) (If yes give war or dotes of service) No **577-07-9733**A Doris O. Haight crematian, 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN burial transit PART I. DEATH WAS CAUSED BY. ONSET AND DEATH Myocardial Infarction IMMEDIATE CAUSE (a). signed by Page 4 may be retained by the hospital or attending physician. DIJE TO Canditians, if any, which gave Coronary arteriosclerosis with thrombosis nse ta immed ate cause (a), DUE TO stating the underlying cause Generalized arteriosclerosis 19 WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBLTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bronchopneumonia, pyelonephritis, acute and chronic, Carcinoma U. Blad. YES THE NO T Ь 206. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part it of Item 18) 20g ACC DENT WAS UNDERLYING [ OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, farm, (C ty ar town) 20c TIME OF INJURY Month, Doy, Year (County) (Stote) Hour a.m. factory, street, affice bldg., etc.) Nat While 21. I certify that (1) (this haspital) attended the deceased fram 7-29 19 67, to 9-3-, 19 67, that (1) (we) lost saw the deceased alive on 9-3-19 67, and that death accurred at 2:16 PM, from causes and on the date stated above. 22b. DATE SIGNED 220 SIGNATURE STAFF 0-4-67 M.D. DIRECTOR PHYS. 0410 Old Georgetown Rd. PHYSICIAN S NAME (Type) BARR Bethesda. Ma vland directar, shaud by 236 DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23a BURIAL, CREMATION, (County) 9-6-67 Parklawn Cemetery 0 Rockville Maryland 24. FUNERAL DIRECTOR 250. REC'D BY REGISTRAR PUMPHREY, Bethesda, Maryland DATE SEP



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12621 CERTIFICATE OF DEATH PLACE OF DEATH COUNTY Montgomery **OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o. SIAWash. D.C. b. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town) Silver Spring on papers. Pag Within 72 haurs 9 Mos. Wash. D.C. filled in d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE DN A FARM2 2500 Q St. N.W. Althea Woodland Nursing Home NO.X NAME OF First Middle 4. DATE Month Doy Year carban campletely DECEASED Sara SEPT Hamner 19 6 7 event (Type or print) DEATH S SEX 6. COLOR OR RACE 9. AGE (In years IF UNDER 1 YEAR IF LINDER 24 HRS 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 86 birthdoy) Months Female White Dovs Hours Min 11-4-1886 WIDOWED DIVORCED and in an gug 10o USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CIT ZEN OF WHAT INDUSTRY COUNTRY physician ( nen please during most of working the even if retired) Mississippi 14 MOTHER'S MAIDEN NAME 13. FATHER S NAME ar remava Thrower Thomas A. Sale 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) If I ves give wor or dates of service) 2500 Q St. N.W. No Longstreet INTERVAL BETWEEN ONSET AND DEATH 18. CAUSE OF DEATH (Enter only one couse per time for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY: burial-transit IMMEDIATE CAUSE (d) this certificate has been signed by **O HOSPITAL OR ATTENDING PHYSICIAN:** The law requires the Page 4 may be retained by the hospital ar attending physician. DUE TO Conditions, if any, which gave rise to immediate couse (a). DUE TO stating the underlying couse as the of Health priar to WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) YES [ NO 206. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Part II of Item 18.) 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Doy, Yeor 20d INHIRY OFGIRRED 20e PLACE OF NJURY (Home, form, (City or fown) (County) (State) Hour a.m. factory, street, office bldg., etc.) Not While of work DIRECTOR: After 19 60 to 21. I certify that (1) (this haspital) attended the deceased fram. 196 (that (1) (we) las 19 6 I and that death accurred at 2:554 Mrom causes and on the date stated above sow the deceased alive on 22b. DATE SIGNED 22o SIGNATURE MED DIRECTOR STAFF PHYS 22d. ADDRESS PHYSICIAN'S TO FUNERAL NAME (Type) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) 230. BURIAL CREMATION. BUT (Specify) 9-22-1967 Miss. Old Odd Fellows 250. RECDENCES 24. FUNERAL DIRECTOR VR A15 (4) Jos. Gawler8s Sons 5130 Wisc. Ave. N.W. DATE 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W, PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 12622 PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death death y the funeral Pages 1 and ond PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. COUNTY o STATE **b.** COUNTY van papers. Pages 1 within 72 haurs after b. (IIY OR TOWN ("Voltside corporate "mir write RURAL and give nearest town) MARYIAND c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside comprote limits, write RURAL and give negrest town) ≘ IS RESIDENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS filled 1 YES NO NAME OF pgu 4. DATE Month Doy Year etely DECEASED (Type or print) OF DEATH event annan 19 ai a a SEX IF LUNDER 74 HRS 6 COLOR OR RACE 7. MARRIED DATE OF BIRTH 9 AGE (In years **NEVER MARRIED** lost birthday) Months Hours Days ond in ony 7 eyan le WIDOWED DIVORCED 1902 Cang. B 105 KIND OF BUSINESS OR 10o USUAL OCCUPATION (Give kind of work done 11 BIRTHPLACE (County & State, or foreign country) 12 CIT ZEN OF WHAT physicion of physicion of physicion of the physicion of t during most of working life, even it retired) COUNTRY? INDUSTRY 4.5. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME burial, cremotion, or removol, ottending phys HEGH WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT (Yes, no. or unknown) i(If yes give wor or dotes of service ECORDS 18 CAUSE OF DEATH (Enter only one couse per line for (a), (b)
PART 1 DEATH WAS CAUSED BY INTERVAL BETWEEN signed by the burral-tronsit p PASET AND DEAT IMMEDIATE CAUSE (o) **TO HOSPITAL OR ATTENDING PHYSICIAN:** The low requires the Page 4 may be retained by the hospital or attending physician. DUE TO Conditions, if any, which gove (b) rise to immediate couse (a), DUE TO stoling the underlying couse ie H State Dept. of Health prior to hos been last 05 WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) loue NO C certificate 5 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port II of Item 18.) 200 ACCIDENT WAS UNDERLYING E OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 20f (City or town) (Stote) 20c. TIME OF INTURY Month, Doy, Year (County) IO MUNERAL DIRECTOR: After this Hour Tolon. foctory, street, office bldg., etc.) Not While ot work at work 21. I certify that (I) (this haspital) attended the deceased fram and that death accurred a M, from/causes and an the date stated above saw the deteased alive an 220 SIGNATURE DIRECTOR PHYS PHYS abod 22d. ADDRESS 22c PHYSICIAN'S director, po-NAME (Type) 23d BURIAL, CREMATION DATE THEREOF ((County) (Stote) REMOVAL (Specify) 250 RECD BY REGISTRAR 2Sb REGISTRAR'S SIGNATURE FUNERAL DIRECTOR VR A15 (4) 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12814 12623 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death funeral PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institut an Residence befare admission) b. countyrince George o. COUNTY rely filled in by the fur ban papers. Pages / within 72 hours offer CATOCACRE MARYLAND R TOWN (If autside corporate limits, RURAL and give newest town) c. LENGTH OF STAY IN 16 c CITY OR TOWN/(If autside carparate limits, write RURAL and give nearest town) INSTITUTION (If not in haspital, give street address) YES NO 3 NAME OF pgu Rambo and campletely DECEASED OF DEATH (Type or print) reprove to 7. MARRIED NEVER MARRIED 8 DATE OF BIRTH AGE (In years last birthday) Manths Days Hours DIVORCED WIDOWED 10b KiND OF BASINESS OR Store Woodward & Lothrup 100 USUAL OCCUPATION (G ve kind of work done 12 CITIZEN OF WHAT and in physician a during most of working life, even if retired) COUNTRY? IRENTON. 43. FATHER'S NAME 14. MOTHER'S MAIDEN NAME burial-transit permit. Then pl burial, crematian, or remaval, David K. Harker XXXXXX Georgianna Cooper INFORMANT 16. SOCIAL SECURITY NO 720-14-6370 36 2/1110 CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY MMEDIATE CAUSE (a) signed by be retained by the haspital or attending physician. DUE TO Canditians, if any, which gove rise ta immediate cause (a). DUE TO stating the underlying couse After this certificate has been be detached far use as the State Dept. af Health priar ta WAS AUTOPS'
PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE COND T ON GIVEN NO V O FUNERAL DIRECTOR: After this certificate 20a ACCIDENT WAS UNDERLYING □ 20b DESCRIBE 60W INJURY OCCURRED (Enter number of anjury in Part I at Port It of Item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20e. PLACE OF INJURY (Home, form, 20c TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20f. (City or town) (County) (Stote) Rour a m Not While factory, street, affice blda, etc.) from 1/23, 1962, to 9/20, 1967, that (I) (see) lost and that death occurred at 6/02M, from causes and on the date stated above. 21. I certify that (1) (this hasand) 19.6.7, that (1) (200) lost oftended the deceosed from page 3 should be filed with the saw the deceased alive an 226. DATE SIGNED ATTENDING PHYS M.D DIRECTOR Page 4 may b PHYSICIAN S 22d\_ADDRESS NAME (Type) director, 1 23d LOCATION (City or Town) BURIAL, CREMATION (County) REMOVAL (Specify) 1967 Port Lincoln Prince Georges Co. Maryland 1987Sb REGISTRAR'S SIGNATURE C.Glen Carter 843400 Georgia Ave. VR A15 (4) 25M 1/67 Silver Spring DATE Pumphrey



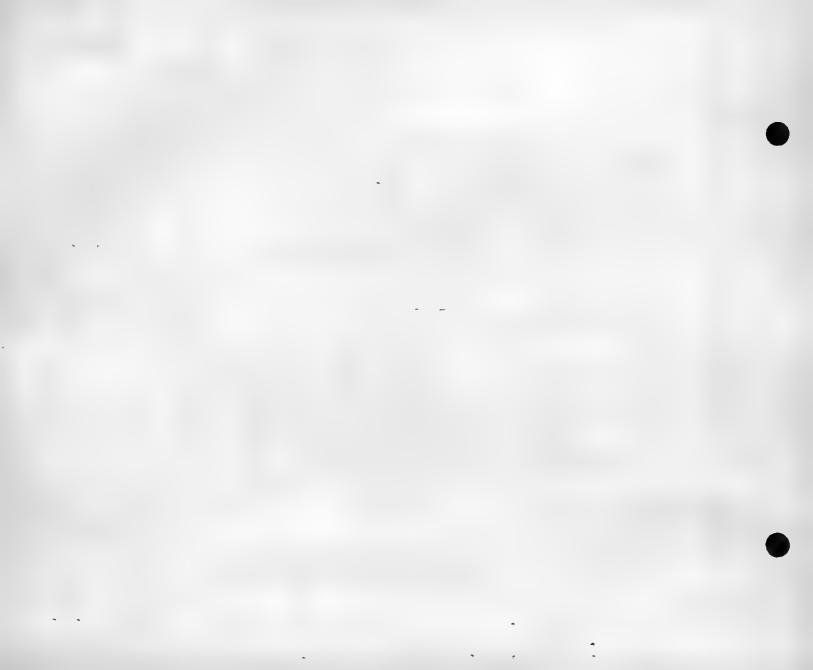
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1	1			DIVISION OF VITAL RECORDS, 301 W, PRES	STON S	TREET, BALTIMORE,	MARYLAND 21201	
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and the same of th	24 hours after death ed in by the funeral ppers. Pages Land of 72 hours ofte death			ACE OF DEATH	2.1	USUAL RESIDENCE (Where	deserised lived, if institut	ion Residence befare odm splan)
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	e death certificate be executed within 24 haurs after deat ottending physician and campletely filled in by the funeral permit. Then please remave carbon papers. Pages Landan, or remaval, and in anywevent, within 72 haurs after deat	í		3 u heer ban	16	1020 14	L gengue.	- /410 YES NO NO
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	ifica aysic at, c		13.	ATHER S NAME	14.	MOTHER'S MAIDEN NAME	-n 17.	/
	cert Paralliper Mac			Robert Hally man	_ /	Mary	1/10001	tine.
	requires that the death certificate be executed within g physician.  signed by the ottending physician and campletely filling burial-transit permit. Then please remaye carbon poar burial, crematian, or remayal, and in any event, buthir a burial, crematian, or remayal, and in any event.		15. (Ye:	WAS DECEASED EVER IN U.S. ARMED FORCES?  na, or Jinknown) (If yes give wor or dotes of service)  12	7 INFOR	RMANT	Addre	so / Sance-
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	the the sit puntition			18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fulmonary infarct	hion	mul +inlo	hilatamal	ONSET AND DEATH
	equires that the physician. signed by the burial-transit in burial, cremati			DUE TO	CLOII,	murring.	OTTRIGUAL	2 weeks
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	<b>OR ATTENDING PHYSICIAN:</b> The law requires the be retained by the haspital or attending physician. <b>DIRECTOR:</b> After this certificate has been signed by je 3 shauld be detached for use as the burial-traried with the State Dept. af Health prior ta burial, cre-		1 CERTIFICATION	200 ACCIDENT WAS UNDERLYING  DR CONTRIBUTING CAUSE OF DEATH IF EITHER, NOTIFY MEDICAL EXAMINER)	ED (Enfer	nature at injury in Part I	or Port It of item 18)	
	DING PHYSIC by the haspit (fter this certi) be detached State Dept. af		MEDICAL			INJURY (Hame, form, treet, affice bldg., etc.)	20f. (City ar tawn)	(Caunty) (State)
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	ed bed bed bed bed bed bed bed bed bed b			21. I certify that (I) (this saw I) attended the deceased from saw the deceased alive an Saw 1919(1967), and the		The accurred at 50		, 19 <u>47</u> , that (i) ( <del>we</del> ) last and an the date stated above.
	R ATTENE retained RECTOR: A 3 shauld with the			22a SIGNATURE 2				22b. DATESIGNED
	OR /			marrin yader	M.D P	ATTENDING MED. PHYS. DIREC	TOR PHYS	9/15/6)
	O HOSPITAL OR ATTENDING PHYSICIAN: The law ra Page 4 may be retained by the haspital ar attending O FUNERAL DIRECTOR: After this certificate has been directar, page 3 shauld be detached far use as the should be filed with the State Dept. af Health prior ta	1		22. PHYSICIAN'S NAME (TYPE) MARVIN WAVLER MI	P.	22d. ADDRESS 8 2/8 6	Visc , Av	, Beth had
	COSE 4 CONE		23a	BUR AL CREMATION, 23b DATE THEREOF 23c NAME OF CEMETERY OF SEMOVAL (Specify) 9/9/967 GATE OF	OR CREMI	ATORY 2	3d. LOCATION (City or To	
	5 Pag 5 Pag 4 Pag	V			1279		ILORA SPRIM	c-MONT MD.
	VR A15 (4) 25M 1/67	D	24.	FUNERAL DIRECTOR ADDRESS  L. J. Demlus Silver Survey of	m	DANSEP I	9 1967 25h	GATRAR S EIGNATURE



Ή,		1281	G		CERTIFICATE	OF DEATH			1262	25	
1		COUNTY MOY	ntgomery		MARYLAND	2 USUAL RESIDENCE G. STATE V1r	Where deceased ginia	ived, if instituti b. COUN	an: Residence be TY	fore admissi	an) 🏑
	b	CITY OR TOWN (	f autside carparate limits	,	L day	CITY OR TOWN (If a	ington	mits, write RUR	At and give nea	**	3
		Naval P	AL OR INSTITUTION (If no Hospital	it ≈ haspital, gi	ve street address)	d. STREET ADDRESS S 3016/Bu	chanan S	treet		e IS REST ON A F YES	DENCE ARM? NO
	- (1	AME OF ECEASED ype ar pnnt)		ian	C.	HART	4. DATE OF DEATH		ember 28	- 17	67
		le	6 COLOR OR RACE Cauc	7 MARRIED WIDOWED	DIVORCED	Sept. 27,	1967	GE (in years ist birthday) yrs	Manths Bpy	s Haurs	Min.
l	diff. L	g masky Warking	N (Give kind af work dane life, even if retired)	106 KIN	D OF BUSINESS OR USTRY N/A		o, Virgi		12 CITIZEN COUNTR		3A
		Patrick !	r. Hart			14. MOTHER'S MAIDEN France	s Rams				
	1S (Yes	WAS DECEASED EVE DO. FUNKNOWN)	R IN U.S. ARMED FORCES? (If yes give war ar dates a	of service) 16. S		FORMANT BUC R Patrick	hanan St T. Hart,		s Arling 3016 Son		va.
		PART 1. DEAT  PART 1. DEAT  Canditians, if any, rise to immediat stating the under last.	relying cause DUE	(o) (d) (d) (d) (d) (d) (d) (d) (d)	Clarena St. Blackers L. D. DEATH BUT NOT RELATED TO TO	manage Domail	140,000	Magazi (G)	2 6	ONSET AND I	
-1		DADT II OTUED CI		OMINIBUTING I	DEATH BUT NOT KELATED TO	DE TEKMINAL DISTANT CO	MUNION OTTEN	1 1 Met 1(a)		PERFORM YES	NO
	FICATION		•	l ann nes	COIDE HOW INHIDA ULLIBBED 1	Enter nature of warm in	Port Lor Port II	of item 183		100	
	CERTIFICATION	200 ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY	IS UNDERLYING  CONTROL CAUSE OF DEATH MEDICAL EXAMINER)		CRIBE HOW INJURY OCCURRED. (						(State)
	L CERTIFICATION	20a ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY 20c. TIME OF INJU Hour a.n p.n	S UNDERLYING CO CAUSE OF DEATH MEDICAL EXAMINER) URY Manth, Day, Year m., 19	20d. IN While at wark	JURY OCCURRED 20e. PLAC  Nat While factor  at work	E OF INJURY (Hame, far iry, street, affice bldg., etc	m, 20f. (C	ity or town)	(Caunty)		(State)
	CERTIFICATION	200 ACCIDENT WAR OR CONTRIBUTING (IF EITHER, NOTIFY 20c. TIME OF INJU- Hour a.n p.n 21. I certi saw the d	IS UNDERLYING COME CAUSE OF DEATH MEDICAL EXAMINER)  URY Month, Day, Year m., 19  ify that DS (this has	20d. IN While at wark	JURY OCCURRED 20e. PLAC	E OF INJURY (Hame, far ary, street, affice bldg., etc	m, 20f. (C	ity or town)	(Caunty) 28 , 19 67, and an the d	that (i); (late state	(we) la:
	CERTIFICATION	200 ACCIDENT WAR OR CONTRIBUTING (IF EITHER, NOTIFY 20c. TIME OF INJUMENT OF I	SUNDERLYING  CAUSE OF DEATH MEDICAL EXAMINER) URY Manth, Day, Year m. 19 ify that (X) (this has leceased glive on	20d. IN While at wark	JURY OCCURRED 20e. PLAC Not While of work of the deceased from	E OF INJURY (Hame, far rry, street, affice bldg., etc. ept. 27, death accurred a	m, 20f. (C	Sept.	(County) 28, 19,67, and an the c	that (i); (late state	(we) la:
	MEDICAL CERTIFICATION	200 ACCIDENT WAS OR CONTRIBUTING (IF EITHER, NOTIFY 20c. TIME OF INJU- 21. I certi saw the 22a. SIGNATURE	SUNDERLYING COME CAUSE OF DEATH MEDICAL EXAMINER) URY Manth, Day, Year m. 19 ify that (X) (this has leceased plive on	20d. IN While at wark pital) attend	JURY OCCURRED  Not While of wark  led the deceased fram \$28_1967_, and that	E OF INJURY (Hame, far any, street, affice bldg., etc. Sept. 27, death accurred a ATTENDING PHYS. 22d. ADDRESS Naval	m, 20f. (C 19.67, to 1230pM, f MED. DIRECTOR [	Sept.; ram (auses    SIAFF PHYS. 5c	(Caunty) 28, 19,67, and an the a 22b. DATE S 28 8	that (ix) late state GRED 196 Septen	(we) la d abay of nber
	MEDICAL CERTIFICATION	200 ACCIDENT WAR OR CONTRIBUTING (IF EITHER, NOTIFY 20c. TIME OF INJUMENT OF I	SUNDERLYING COME CAUSE OF DEATH MEDICAL EXAMINER)  URY Manth, Day, Year m., 19  ify that (b) (this has beceased plive on	20d. IN While of work spital) attence Sept M.D.	JURY OCCURRED  Not While of wark  ed the deceased fram \$\frac{2}{2}\$. 1967., and that	E OF INJURY (Hame, far any, street, affice bldg., etc.)  Sept. 27 , death accurred a  ATTENDING PHYS.   22d. ADDRESS Naval  REMATORY	m, 20f. (C 19.67, to 1230PM, f MED. DIRECTOR [ Hospita]	Sept. : ram (auses  STAFF PHYS. & DON (City or Total	(Caunty) 28, 19,67, and an the a 22b. DATE S 28 8	that (b) (late state IGNED 196 Septen	(we) la d abav



MARYLAND STATE DEPARTMENT OF HEALTH 12617 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12626 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 hours after death. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) g. COUNTY MONTGOMERY e corbon popers. Pages I **MARYLAND** b CITY OR TOWN (If autside corparate limits, write RURAL and give nearest town) t LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) SILVER COTTAGEVILLE 5PRING d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM Box P. D. YES NO CROSS NAME OF completely f Middle 4. DATE Lost Day Year DECEASED (Type or print) OF DEATH HARVEY SEPT. RUFUS 196 IF UNDER 1 YEAR S. SEX 6 COLOR OR RACE 9 AGE (In years 7. MARRIED NEVER MARRIED lost birthday) NOV. 12, 1901 WIDOWED 11. BIRTHPLACE (County & Stote, or foreign country) 10a, USUAL OCCUPATION (Give kind of work done 106. KIND OF BUSINESS OR 12. CITIZEN OF WHAT during most of working life, even if retired) ottending physicion termit. Then please Georgia Retired Mechanic 14. MOTHER'S MAIDEN NAME 13 FATHER'S NAME buriol, cremation, or removal, Unknows 17. INFORMANI 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO Address 2923 UNIVERSITY BLU (Yes, ng, pr unknown) (If yes give war ar dates of service MRS. ARIENE RESISTER 249-03-7448 IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gave athorns rleurs, nse ta immediate cause (a), DUF TO stoting the underlying cause PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE COND TION GIVEN IN PART .(a) 19 WAS AUTOPSY PERFORMED? Rundla NO 20g ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port I) of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20f. (City or town) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 20d INJURY OCCURRED 20e, PLACE OF INJURY (Hame, farm, (County) (State) Not While foctory, street, office bldg., etc.) al wark TO FUNERAL DIRECTOR: After 21. 1 certify that (1) (this hospital) attended the deceased from AUG. ( , 1967, to SEPT. 18, 1967, that (1) (we) lost sow the deceased alive on SEPT. 18 1967, and that death occurred at 300 M, from causes and on the date stated above. 220 SIGNATURE 226. DATE SIGNED PHYS DIRECTOR 22d ADDRESS 22c PHYSKTÁN'S KOBERTSMID. 8907 GEORGIA AVE. SILVER SPRING, MD. NAME (Type) 23d LOCATION (City or Town) 23c NAME OF CEMETERY OR CREMATORY BURIAL CREMATION REMOVAL (Specify) 1967 Riverview Memorial Park Worth Charleston, S. 2So. REC'D BY REGISTRAR 25b. REGISTRAR S SIGNATURE ADDRESS Georgia Avenue VR A15 (4) 25M 1/67 DATE SEP



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12627 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) PLACE OF DEATH o COUNTY MARYLAND TOWN (If our de corporate c. LENGTH OF STAY IN 16 autside carporate limits, write RURAL and a ve nearest town write RURAL and give nearest town) NAME OF HOSPITA OR INSTITUTION (If Not in haspital, give street address) e IS RESIDENC ⊑ ON A FARM YES NO NAME OF Middle Year completely DECEASED Loto OF DEATH (Type or print) SFX AGE (In years IF LNDER 1 YEAR IF UNDER 24 HRS 7, MARRIED NEVER MARRIED lost birthday) Months Dovs Hours WIDOWED DIVORCED TOB KIND OF BUSINESS OR 10o USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & Stote, or foreign country) 12 CITIZEN OF WHAT during most of working ite, even if retired) INDUSTRY Monticello, Indiana souservice. WW HOME 14 MOTHER'S MAIDEN NAME 13 FATHER'S NAME Lida M. Straight Charles D. Gardner Tred C. Hasselbring Silver Spring, Md. 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, na, prunknown) (If yes give war ar dates of service) 12-22-2554 18 CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c) ) INTERVAL BETWEEN PART 1 DEATH WAS CAUSED BY OWSET AND DEATH Bilateral Bronchopneumonia IMMEDIATE CAUSE (a) 1 56 de W DUE TO Pheumatoid Arthritis Conditions, if any, which gave rise to immediate cause (a). DUE TO stoting the underlying couse hos been lost. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) **ASHD** NO 2Dd ACC DENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part 1 of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e, PLACE OF INJURY (Hame, farm, (City or town) (County) (State) Haur a.m. factory, street, office bldg, etc.) While Not While ot work 21 I certify that (1) (this haspital) affended the deceased fram and that death accurred at . 2. 2 14 TO FUNERAL DIRECTOR: saw the deceased alive an\_ from causes and an the date stated above 22a SIGNATUR 22b DATE SIGNED DIRECTOR PHYS. MD director, page 3 22c PHYSICIAN O HOSPITAL NAME (Type) 10620 Georgia Ave., SilverSpring, John J' Curry, M.D 235 . NAME OF CEMETERY OR CREMATORY 23d LOCAT ON (City or Town) 23a BUR AL CREMATION rew (emetery REMOVAL (Specify) 1. onticello. 25g. REC'D BY REGISTRAR VR A15 (4) 25M 1/67 DATISEP 196



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12628 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. filled in by the funeral Trappers. Pages 1 and 2 whin 72 haurs after death PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. Montgomery o. STATE Maryland b COUNTY MARYLAND Montgomery CLENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate firmits, write RURAL and give nearest tow b. CITY OR TOWN (If autside corporate limits, Write RURAL and give nearest town) 1 hr.42 min. d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS S RESIDENCE ON A FARM? filled Montgomery Gereral Hospital conson por NO D 3. NAME OF Middle Lost physician and completely DECEASED OF DEATH Baby Boy Hawkins (Type or print) IF UNDER 24 HRS S SEX 6. COLOR OR RACE DATE OF BIRTH AGE (In years IF UNDER I YEAR 7. MARRIED NEVER MARRIED 2 lost birthday) Months 9/17/67 M White and in any WIDOWED DIVORCED 10o JSUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 (IT ZEN OF WHAT COUNTRY? USA during most of working life, even if retired) INDUSTRY Montgomery, Maryland 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME ar remayal, Leroy B. Hawkins Linda L. Whetzel 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) (If yes give wor ar dates al service) 16. SOCIAL SECURITY NO 17 INFORMANT Address Leroy B. Hawkins. Item 2 INTERVAL BETWEE 18 CAUSE OF DEATH (Enter only one couse per line for (p). (b), and (c).) PART I DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) by the haspital or attending physician DUE TO Conditions, if ony, which gove rise to immediate couse (a), **DUE TO** ertificate has been sed for use as the batter of Health prior to be stating the underlying couse last PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS ALTOPS PERFORMED? certificate 20g ACCIDENT WAS UNDERLYING [ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I at Part II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 3 20d INJURY OCCURRED 20c TIME OF INJURY Month, Doy, Year 20e PLACE OF INJURY (Home, form, 20f (City or fown) (County) (Stote) 8 Hour to m. Not While factory, street, office bldg , etc.) of work 2). I certify that (1) (this haspital) attended the deceased from 9-17, 1967, to 9-17, 1967, that (1) (we) last 4 may be retained 19 67, and that death accurred at 16:45 AM, from causes and on the date stated above TO FUNERAL DIRECTOR: saw the deceased alive an 22o SIGNATURE ATTENDING M.D DIRECTOR filed PHYS 22c. PHYSICIAN'S 22d ADDRESS O HOSPITAL NAME (Type) L. S. Batman, M.D. Damascus, Md. director, 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23a. BURIAL, CREMATION, (County) Dept.19,1967 Damascus Meth. Damascus, Md. 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR ADDRESS 2Sb REGISTRAR'S SIGNATURE Olin L. Molesworth, Damascusl Md. VR A15 (4) 25M 1/67



12520

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CEDTICICATE OF DEATH

12629

W =					CEKII	FICATE	OF DEATH				
and death		LACE OF DEATH				7	USUAL RESIDENCE (	Where deceased live	d, if institution (	Residence before c	idmission)
	(	COUNTY	BOMERY (	2	MA	RYLAND	a STATE MAD	YLAND	b COUNTY		
s. Pages haurs afte	-		(If outside corporate or	mits.	c. LENGTH OF STAY		CITY OR TOWN (If a	utside corporate limit	s write RtIRAL c	and nive pearest t	nwn)
gu S		write RURAL o	and give nearest town)	.,,,,,	16day	- 11	·		3, 11110 11010110 0	tio grow transaction in	, ,
iin 72 haurs		WHEAT	PITAL OR INSTITUTION (IF	Caracta Bassina			KENSING STREET ADDRESS	HON		La	IS RESIDENCE
7 ,							4107 PI	VEDS MI	LL Rd	[ 6	ON A FARM?
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		IAME OF ECEASED		First	Middle	11	Lost	4 DATE OF	Month	Doy	Year
1)	(	Type or print)	DENJAM	IIN	C,		4WKINS	DEATH	Sept	. 16,	1961
" //I		EX	6 COLOR OR RACE	7 MARRIEI	NEVER MARRI		DATE OF BIRTH	9. AGE	(In years IF birthday) Mo		Haurs Min.
		YALE	C	WIDOWE	DIVORC	ED 🔲 🕻	3-12-188	0 8	7 yrs	initis Doys	Mille.
	100	USUAL OCCUPATION	ON (Give kind of work do	ne 10b	KIND OF BUSINESS OR		11. BIRTHPLACE (County	& State or fareign co	ontry)	12. CITIZEN OF W	/HAT
	auri	ng mas for working	orer (Ke)	Trea)	INDUSTRY		MARYLA	ND		COUNTRY?	ISA.
i		FATHER'S NAME				1	4. MOTHER'S MAIDEN				
remova		JAM	es HAU	IKINS	5		LIZA				
			VER IN U.S. ARMED FORCE		SOCIAL SECURITY NO	17 INF	ORMANT		Address		
ō	(Ye	, no, or unknown	) (If yes give wor or dote	es of service)	19-12-470	364					
<u> </u>	-	IR CAUSE OF	DEATH (Enter only one							INTER	VAL BETWEEN
crematian,	- 1	PART I. DE	ATH WAS CAUSED BY.	6.1			. 0 80.			ONSET	AND DEATH
			IMMEDIATE CAU	UE TO	acce-		7			30	ange
٠		Conditions, if or		(h)	0 .1011	10-11	i a de	** *		160	d . a.trus
	- 1	rise ta immedi	ate cause (a), ( 💎 🙀	UE TO		<u> </u>				7	
	1	stating the und	lerlying couse	(c)							
	ł		SIGNIFICANT CONDITIONS		TO DEATH BUT NOT D	FLATED TO THE	TERMINAL DISEASE CO	NINITION GIVEN IN P.	APT I(a)	119. W	AS AUTOPSY
	CERTIFICATION	TAKE II OTTEK	JOHN COMPTION	J CONTRIBOTING	TO DEATH BOT NOT K	COCICO TO THE	TERMINE DISERSE CO	NIDTHON CIVER IN T	ari i(a)		AS AUTOPS Y REORMED? NO TZL
- 1	3	ACCIDENTAL	AS JNDERLYING	Tank	DESCRIBE HOW INJURY	OCCURRED /C-		Dark Law Dark Harf		YES	U N∪ La
	EXI	OR CONTRIBUTIN	IG □ CAUSE OF DEATH	200	DESCRIBE HOW INJURE	OCCURRED (EII	יפר ויסוטוצ מד וויזטינץ יו	Pair I or Poir II of I	rem to;		
	Ä.	<u> </u>	Y MEDICAL EXAMINER)		MINISH OCCUPAN	DO COLOT	ar Malifell 1a	T pot 16.	11	17	(5 )
	MEDICAL	200 TIME OF IN	LURY Manth, Day, Year o.m.	Whi	INJURY OCCURRED  le  Not While		OF INJURY (Home, forr , street, affice bldg., etc.		or town)	(County)	(State)
	≥		7 116.	9 at w	ork 🗀 at wark 🗀	J					
			tify that (I) (this h		nded the decease	d fram	167	19, ta 91	6/67	, 19, that	(I) (we) last
			deceased alive an	9/12	1967.	and that d	leath acturred at	M, tron			stated abave.
*		22g SIGNATUR	51-0	- Cha			ATTENDING	MED DIRECTOR C	STAFF -	22b. DATE SIGNED	1-
. (			March	Ya	Meri	74 MD	PHYS.	DIRECTOR L	PHYS.	4116	6/
		22c. PHYSICIAN NAME (Typ		U			22d. ADDRESS	seavera	Ch	res 8mi	ua Mid
'									- 00		
	23g	BURIAL, (REMA	TION, 23b DATE	1	23c. NAME OF CE		1	23d LOCATION	(City or Town)	(County)	(Store)
Shauld		DUR	けんフノス	0/67	MSh	Memo	YIAI	12ANO	140PY	1114 1	1714 , 19 K
PAY	-24	FUNERAL DIREC	OR / Y		ADDRESS)	0-10	2 7 7973	D BY REGISTRAR	2Sb. KEGISTI	RARS SIGNATURE	eder.
11/2		- LO	57 K. /h	un od	A Y has	X100111	DATE CE	n 9 1 196	av vice	CON A X	



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12630 CERTIFICATE OF DEATH haurs after death and PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o STATE Maryland Prince George o. COUNTY MARYLAND Montgomery b CITY OR TOWN (If outside corporate limits. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 **OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 haurs of write RURAL and give nearest town) Silver Spring 12 days Hyattsville d NAME OF HOSPITAL OR INSTITUTION (If not in hospito, give street address) d STREET ADDRESS .⊆ e IS RESIDENC popers ON A FARM? filled i Holy Cross Hospital 5502 40th Avenue YES NO X NAME OF Fifst Middle 4 DATE Month Lost Dov Year DECEASED OF September Kyle 1967 Hawthorne 18 (Type or print) 8 DATE OF BIRTH IF JNDER 1 YEAR IF UNDER 24 HRS S SEX 6. COLOR OR RACE 7. MARRIED **NEVER MARRIED** 9. AGE (In years birthdoy) Months 8/3/04 White WIDOWED Male DIVORCED 100 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 11. BIRTHPLACE (County & State, or fareign country) 12. CITIZEN OF WHAT 10b KIND OF BUSINESS OR COUNTRY? Town &Casual Shoes Virginia Manager 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME burial, cremation, ar removal. Noah B Hawthorne Nettie Grant 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dates of service) 215 07 2098 Marguertie Hawthorne Hyattsville, Md. INTERVAL BETWEEN HB CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c) PART I. DEATH WAS CAUSED BY signed by the burial-transit p ONSET AND DEATH IMMEDIATE CAUSE (o) **DUE TO** Conditions, if any, which gove rise to immediate couse (a). DUE TO stating the underlying couse as the has been lost. WAS AUTOPS PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO. FUNERAL DIRECTOR: After this certificate 20b DESCRIBE HOW INTURY OCCURRED (Enter noture of injury in Port I or Port II of them 18) 200 ACCIDENT WAS UNDERLYING € OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER! 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form (City or town) (County) (Stote) 20: TIME OF INJURY Month, Doy, Year Hour To.m. foctory, street, office bldg., etc.) 19.6 ) that (I) (we) lost 21 I certify that (1) (this haspital) attended the deceased from and that death occurred attan PM, from causes and an the date stated above. sow the deceased alive an \_ 22b. DATE SIGNED 22a SIGNATURE ATTENDING 9/19/67 M.D. NAME (Type) Leonard Deitz, M.D. 1111 Spring Street, Silver Spring, Md 23c NAME OF CEMETERY OR CREMATORY 23o. BURIAL, CREMATION, 23b DATE THEREOF 23d LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) Cedar Hill Cemetery Sept 22, 1967 Suitland Pro Geo Md. 2So REC D BY REGISTRAR 24. FUNERAL DIRECTOR ADDRESS 256 REGISTRAR'S SIGNATURE Hyattsville, Nd. F. Gasch's Sons DATE

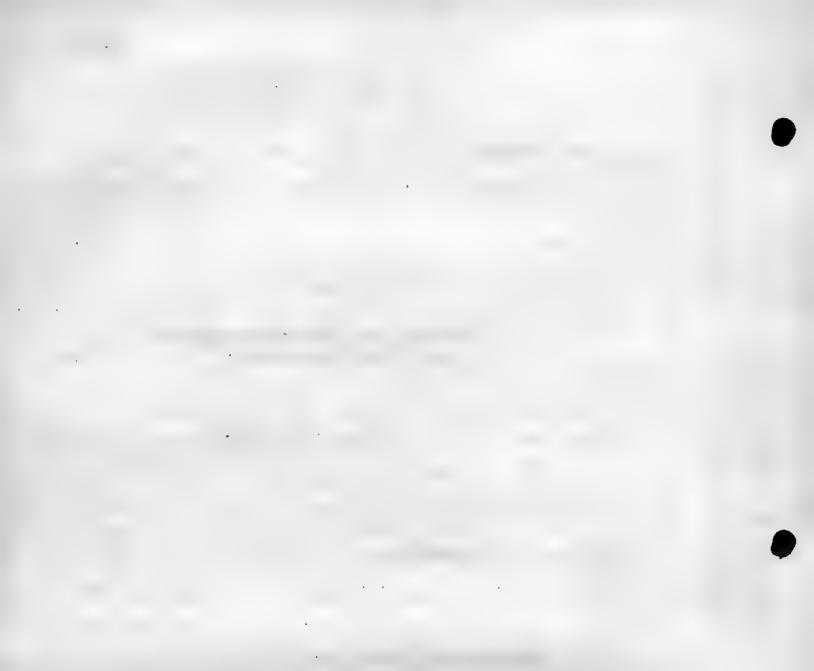


MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH i 2631 PLACE OF DEATH USUAL RESIDENCE (Where decrased lived, If Institution: Residence before admission) a. COUNTY a. STAT b. COUNTY MARYLAND CITY OR TOWN (if outside corporate limits, C. LENGTH OF STAY IN 1b c. CITY OR FOWN (Moutside corporate limits, write RUKAL and give nearest fown) hours d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, glya streat address) d. STREET ADDRESS B. IS RESIDENCE ON A FARM? NO 🔀 YES completely we carbon p event, withi executed within 3. NAME OF DATE Month Day Year DECEASED OF (Type of print) DEATH. 196 5. SE) 6. COLOR OR RACE DATE OF BIRTH 7. MARRIED (In years IF UNDER 1 YEAR OF UNDER 24 HRS NEVER MARRIED physician and c an please removival, and in any e last birthday) Months Hours WIDOWED DIVORCED Loa. USUAL OCCUPATION (Give kind of work done | 10b. KIND OF BUSINESS OR INDUSTRY BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT certificate be during most of working life, even if retired) Maritime FATHER'S NAME been signed by the attending phy the burial-transit permit. Then pl or to burial, cremation, or removal, MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SQCIAL SECURITY NO. 17. INFORMAN Address death (Yes, no, or unknwn) ((If yes give war or dates of service) CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: the hospital or attending physician. IMMEDIATE CAUSE **DUE TO** Cenditions, If any, which gava risa to Immediate DUE TO cause (a), stating has be as th prior 1 underlying cause last. (c) FICATION PART 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION CIVEN IN PART 1(a) certificate hather for use at the post of Health pot. WAS AUTOPSY PERFORMED? YES NO PHYSICIAN: 20a. ACCIDENT WAS UNDERLYING After this certif I be detached fo State Dept. of P DESCRIBE HOW INJURY OCCURRED. (Enter natura of injury in Part I or Part II of Item 18.) OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, farm,) 20f. (City or town) (County) (State) factory, street, offica bldg., etc.) Hour a.m. MEDI After Whila Not While retained by 19 at work p.m. at work director, page 3 should be should be should be should be filed with the St 21. I certify that (I) (this hospital) 19.5 %, to attended the deceased from saw the deceased alive on and that death occurred at 22-SAM, from the causes and on the date stated above. 22a. SICNATURE 22b. DATE SIGNED ATTENDING Page 4 may b PHYS DIRECTOR M.D. PHYS PHYSICIAN'S 22c. 22d. ADDRESS NAME (Type) LBER CUSHNER BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF COMETERY OR CREMATORY LOCATION (CIN Lown or county) tate 23d. 5 <u>e</u> REMOVAL (Specify) FUNERAL DIRECTOR REC'D BY REGISTRAR VR A15 (4) 20M



	12623	CERTIFICATE	OF DEATH	12632
ŧ.	PLACE OF DEATH Montgomery	MARYLAND	e. STATE waryland b.	ved, If institution: Residence before admission COUNTY N.ONTE;
-	b. CITY OR TOWN (if outside corporate limits, write RURA) and give nearest lower	C. LENGTH OF STAY IN 16	c. CITY OR TOWN (If outside corporeta limit Gaithersburg	is, write RURAL and give neerest town)
	d NAME OF HOSPITAL OR INSTITUTION (If not in hos		d STREET ADDRESS 14 Park Ave	e. IS RESIDEN ON A FARA YES NO
3.	NAME OF Fist DECEASED (Type or print) Bessie	Elizabeth	Heim death	Month Dey Year Sept 28th 1967
	SEX 6. COLOR OR RACE 7. MARRIE WIDOWE		April 6th 1884   Age (1)	hday)  Months Deys Hours Min
10 de	. USUAL OCCUPATION (Give kind of work na during most of working life, even if retired) HOME WOLK	IND OF BUSINESS OR INDUSTRY	Gaithersburg. Md.	ountry) 12. CITIZEN OF WHAT COUNT USA
13	FATHER'S NAME Edward Heim		Malinda, Kemp	fa
15 (Y	WAS DECEASED EVER IN U.S. ARMED FORCES? 16. s, no, or unkown) (Ifyesgivewerordatesofservice)	SOCIAL SECURITY NO. 17. 1		Aithersburg. A.
MEDICAL CERTIFICATION	PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  Condillons, If any, which geve rise to immadieta cause (a), steting the underlying DUE TO (c)  PART II. OTHER SIGNIFICANT CONDITIONS CON	Browsha- P	newsponen	ONSET AND DEATH  3 Lacy  3 Clacy
	200 ACCIDENT WAS UNDERLYING   20b. DE:		D. (Enter neture of injury in Part I or Part II of item	PERFORMINITY YES NO
	(IF EITHER, NOTIFY MEDICAL EXAMINER)  20c. TIME OF INJURY Month, Dey, Yeer While Park While at wor	Not While lecto	CE OF INJURY (Home, farm, 20f. (City or town)	(County) (Slete)
	21. I certify that (I) (this hospital) attended the deceased from 9-25- 1967, to 9-25, that (I) (we) la saw the deceased alive on 9-25, and that death occurred at 1. PM, from the causes and on the date stated above			
	220. SIGNATURE  220. PHYSICIANYS  NAME (1709)  T B ACC	m. The Alexander	D. ATTENDING MED. STAFF	9-24-67 SIG
23	BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify)	23c. NAME OF CEMETERY C		City, town or county) (Stofe) ersburgd.
`	FUNERAL DIRECTOR'S SIGNATURE			





MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12625 12634 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) o. COUNTY Montgomery o. STATE **b.** COUNTY NA N.C. MARYI AND c LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside corporate limits write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, Midway Park 2 Days Na d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e IS RESIDENC Naval Hospital Bethesda, Maryland Butler Ave NAME OF First Last DATE Year DECEASED (Type or pnnt) HELTON Jr. David Lee 67 9 DEATH S SEX 6. COLOR OR RACE 9 AGE (In years 7 MARRIED NEVER MARRIED B DATE OF BIRTH IF JNDER 1 YEAR IF UNDER 24 HRS. last birthday) Cauc 15 AUG 1967 Male WIDOWED Na DIVORCED 10b. KIND OF BUSINESS OR 10a USJAL OCCUPATION (Give kind of work done 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) NOUSTRY **COUNTRY?** Camp Lejeune. N.C. 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME ar removal. David Lee Helton Sr. Phyllis Smith IS WAS DECEASED EVER IN J.S. ARMED FORCES? 17 INFORMANT 16. SOCIAL SECURITY NO 315 Butler Drive (Yes, no, acynknawn) (If yes give war ar dates af service) David Lee Helton Sr. Midway Park, N.C. Na IB. CAUSE OF DEATH (Enter only one cause per fine for (o), (b), and (c).)
PART I DEATH WAS CAUSED BY: INTERVAL BETWEEN signed by the burial-transit ONSET AND DEATH Congenital Heart Disease IMMEDIATE CAUSE (a) DUE TO Tetralogy Of Fallot Conditions, if any, which gave nse ta immediate cause (a), DUE TO stoting the underlying cause stached for use as the Dept. af Health prior to has been PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(g) 19 WAS AUTOPSY PERFORMED? None certificate NO X 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.) 20g ACC DENT WAS UNDERLYING [ OR CONTRIBUTING CAUSE OF DEATH Na (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Manth, Day, Year 20d INJURY OCCURRED 20e, PLACE OF NJURY (Home, form (City or town) (County) (State) TO FUNERAL DIRECTOR: After this Nactory, street, affice bldg., etc.) Not While ATTENDING Na at work 21. I certify that (I) (this hospital) ottended the deceased from 2 Sept 1967 to 4 Sept 19 67, that (I) (we) lost Page 4 may be retained saw the deceased alive on 14 Sept 1964, and that death accurred on 240AM, from causes and on the date stated above. 22b. DATE SIGNED 22a, SIGNATURE **ATTENDING** MED. DIRECTOR STAFF X □ 4 SEPT 67 M.D PHYS Naval Hospital, Bethesda, Md. 22c. PHYSICIAN'S MONEY A.F. TOMPKINS NAME (Type) 23c NAME OF CEMETERY OR CREMATORY 230 BUR AL, CREMAT ON 23d LOCATION (Csty or Town) (County) (Stote) BREMOVAL (Specify) Richmond, Indiana Earlham Cemetery Stegall- Burghade & Orr DATE SEP BY REGISTRAPS 67 24 FUNERAL DIRECTOR VR A15 (4) (For R.A. Mumphrey Richmond . Indiana 25M 1/67

J ' , ' D ' , Ų.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 hours after death 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) filled in by the funeral papers. Pages 1 and PLACE OF DEATH a COUNTY Maryland **b** COUNTY Montgomery Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) c CITY OR TOWN (If autside corparate limits, write RURAL and give necrest town) CLENGTH OF STAY IN 16 42 Days Wheaton Bethesda (rural B IS RESIDENCE ON A FARM? d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) 2610 Weller Rd. Naval Hospital YES NO 1 3. NAME OF 4 DATE Midde Manth Year Lost Day copptendy i DECEASED September 28 HIGGINS (Type or print) Montgomery Earle DEATH IF UNDER , YEAR IF UNDER 24 HRS. 9. AGE (In years S. SEX B. DATE OF BIRTH 6. COLOR OR RACE 7. MARRIED **NEVER MARRIED** last birthday) Months Haurs WIDOWED DIVORCED Oct. 29 1879 Cauc Male physician and one one one rem 12. CITIZEN OF WHAT COUNTRY? 100 USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) INDUSTRY Sir Johns Run, W. Va.

14. MOTHER'S MAIDEN NAME Armed Forces IISA U. S. Navy
13 FATHER'S NAME Alice Cross James L. HIGGINS 17. INFORMANT IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 2610 Weller Rd. (Yes, no, or unknown) (If yes give war or dates at service) 579-46-9922-A Montgomery Higgins Wheaton, Md. IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) )
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN burial-transit ONSET AND DEATH IMMEDIATE CAUSE (o) Acute Myocardial Infarction signed by DUE TO Canditions, if any, which gave ise to immediate couse (a), (b) Pulmonary Edema DUE TO stating the underlying cause O IUNIRAL DIRECTOR After this curtificate has been the PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? distached far use NO T 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) 20o. ACCIDENT WAS UNDERLYING be retained by the haspital OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) (Stote) 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (County) 20c, TIME OF INJURY Month, Doy, Year Hour a.m. factory, street, affice bldg., etc.) Nat While TO HOSPITAL OR ATTENDING Page 4 may be retained by the at wark at work . to 28 Sep 21. I certify that (K (this hospital) attended the deceased fram 17 Aug 67, 19 , 19.67, that (# (we) last director, gage 3 shauld when the shauld be filled with the 1967, and that death occurred at 12:5% from causes and on the date stated above. saw the deceased alive on 28 Sent. 22g. SIGNATURE 22b. DATE SIGNED MED DIRECTOR ATTENDING 22d. ADDRESS 22c. PHYSICIAN'S NAME Wrence W. Raymond, M. D. Naval Hospital, Bethesda, Md. 23c NAME OF CEMETERY OR CREMATORY 23g BURIAL, CREMATION, 23b DATE THEREOF 23d. LOCATION (City or Town) (County) (State) Burial (Specify) Arlington National Arlington, Virginia 25b REGISTRAR'S SIGNATURE 2Sq. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR Joseph Gawler & Sons ADDRESS VR A15 (4) 20 M 1/66 Ochanles Judge 5130 Wisconsin Ave., Washington, D. C.



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death. 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) PLACE OF DEATH a. COUNTY o. STATE b. COUNTY Montgomery Maryland Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) c CITY OR TOWN (If gutside corporate timits, write RURAL and give nearest town) c LENGTH OF STAY IN 16 6 weeks Silver Spring filled in d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RES DENC ON A FARM? 11200 Lockwood Dr., Apt. ent within YES NO Y University Nursino Home 608 NAME OF Middle 4. DATE Year and campletely DECEASED Lorna Mae Hill g 16 (Type or print) 19 67 DEATH S SEX AGE (In years IF UNDER I YEAR IF UNDER 24 HRS. 6 COLOR OR RACE 7 MARRIED NEVER MARRIED B. DATE OF BIRTH remove last birthday) Manths Days Haurs Female Caus. Aug. 16. 1891 WIDOWED X DIVORCED 100 USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fareign country) 12 CIT ZEN OF WHAT during most of working life, even if retired) Own home COUNTRY? the attending physician sit permit. Then please Housewife 13. FATHER'S NAME Rearaboo, Wisconsin HSA or remayal, unknown John Young 11200 Lackwood Drive 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dates of service) 213-12-1614 Mr. Lawrence NTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per Interfor (a), (b) and (c) PART I. DEATH WAS CAUSED BY. signed by the burial-transit p IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a). DHE TO stating the underlying cause has been the WAS AUTOPSY PERFORMED? PART IF OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO TO FUNERAL DIRECTOR: After this certificate 草 20g ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City at town) (County) (State) 20c. TIME OF INJURY Month, Doy, Year factory, street, office blda., etc.) Not While at wark ot work 19.67, to 9/16 21. I certify that (1) (this hospital) attended the deceased from Chin , 19<u>.6.7</u> that (I) (<del>we</del>) last be retained and that death accurred at 6 140M, from causes and an the date stated above saw the deceased alive an, 22o. SIGNATURE 226 DATE SIGNED. ATTENDING M D DIRECTOR PHYS. PHYS 22d ADDRES 22c. PHYSICIAN'S NAME (Type) director, should b 23d LOCATION (City or Tawn) 23α BURIAL, CREMATION (Stote) REMOVAL (Specify) Parklawn Cemeteru Rockville Maryland DATESEP 2 1 2Sb. REGISTRAR S SIGNATURE VR A15 (4) licerelas Judge 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12637 12628 CERTIFICATE OF DEATH PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) b COUNTY MARYLAND ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after Y OR TOWN (I outside corporate in its textural and give nearest town) c. LENGTH OF STAY IN 16 outside corporate limits, write RURAL and give neglest fown) NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e IS RESIDENCE ON A FARM? d. STREET ADDRESS YES NO F NAME OF remove carben Middle 4 DATE Year Month Doy campletely DECEASED OF (Type or print) 19 DEATH 60 7 eveni SEX 6 COLOR OR RACE AGE (In years IF UNDER I YEAR IF UNDER 24 HRS 7 MARRIED NEVER MARRIED DATE OF BIRTH last/birthdoy) Months Doys signed by the attending physician and ca burial-transit permit. Then please remov burial, crematian, or removal, ond in any i WIDOWED DIVORCED OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR TRAMPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during mosket working life, even if retired) INDUSTRY awher 13. FATHER'S NAME 14. MOTHER SYMAIDEN NAME 15. WAS DECEASED BY R IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes give wor or dotes of service) 17 INFORMANT TO SOCIAL SECURITY NO Jennie Hitt. Wife Same as Abeve 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) Page 4 may be retained by the haspital ar attending physician. **DUE TO** Conditions, if any, which gove rise to immediate couse (a). DUE TO far use as the b Health priar to b stoting the underlying couse has been last. WAS ALTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) NO CERTIFICAT certificate 200 ACC DENT WAS UNDERLYING [ 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of Item 18.) OR CONTRIBUTING 
CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME DF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour o.m. factory, street, office bldg., etc.) Not While of work O FUNERAL DIRECTOR: After 21. I certify that ((1) (this haspital) attended the deceased from 6 19 67 ta director, page 3 shauld shauld be filed with the 24 1967, and that death accurred at 745 P.M. from causes and an the date stated above. saw the deceased alive an 22b ATTENDING M.D. DIRECTOR PHYS PHYS 22d ADDRES NAME (Type 23c. NAME OF CEMETERY OR EREMATOR LOCATION (City or Town) 230 BURIAL, CREMATION DATE THEREO! (County) (Stote) REMOVAL (Specify) Magnelia Cemetery Augusta Georgia 2Sb REG STRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS 250 REC'D BY REGISTRAR VR A15 (4) 25M 1/67 196 GASCH'S HYATTSVILLE, MARYLAND



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12630 CERTIFICATE OF DEATH The law requires that the deoth certificate be executed within 24 hours after death. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY b. COUNTY MARYLAND by The Pages b. CITY OR TOWN (If outside corporate limits. C LENGTH OF STAY IN 16 c CITY OR TOWN (If gutside corporate limits, write RURAL and give nearest town) write RURAL and give nearest fown)

SILVER SPRING

d NAME OF HOSPITAL OR INSTITUT ON (If nat in haspital, give street address) AURORA d STREET ADDRESS 8 IS RESIDENC ON A FARM? FAIRLAND NURSING HOME NO TE NAME OF F00 Middle 4 DATE Month Day Year DECEASED OF SEPT HOLLCROFT 1967 (Type ar pont) DEATH S SEX IF UNDER 1 YEAR 6 COLOR OR RACE 7 MARRIED NEVER MARRIED DATE OF BIRTH 9. AGE (In years IF HINDER 24 HRS lost birthday) Months Days HOUES WIDOWED 🔀 and in any DIVORCED 10a USUAL OCCUPAT ON (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY. COUNTRY? physician ALTON; IND. HISTORIAN 004 25500 13 FATHER S NAME burial, cremation, or removal, HOLLCROFT WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOC AL SECURITY NO permit. (Yes, no, or unknown) (If yes give wor or dates of service) 111-26-8117A AT NURSING HOME INTERVAL BETWEEN ONSET AND DEATH CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c) ) signed by the burial-transit p PART I. DEATH WAS CAUSED BY. ACUTE IMMEDIATE CAUSE (a) DUE TO Canditions, if any, which gave rise to immediate cause (a). DUE TO stating the underlying couse ‡ ₽ with the State Dept. af Health priar to WAS AUTOPS'
PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) YES -NO O FUNERAL DIRECTOR: After this certificate b 20a ACCIDENT WAS UNDERLYING [ 205 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 11 of item 18.) OR CONTR BUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20e. PLACE OF INJURY (Home, form, (City or town) 20c TIME OF INJURY Manth, Day, Year 20d INJURY OCCURRED (County) (State) Hour a.m. factory, street, affice bldg, etc.) Not While at wark 196 >, that (I) (we) last M, fram causes and an the date stated above , and that death accurred at saw the deceased alive an SET? 220. SIGNATURE 22b DATE SIGNED MED DIRECTOR PHYS PHYSICIAN'S NAME (Type) BURIAL, CREMATION 23b. DATE THEREO 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (Stote REMOVAL (Spessfy) 2So REC'D BY REGISTRAR REGISTRAR'S SIGNATURE DATESEP VR A1II (4) 196 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12638 CERTIFICATE OF DEATH ht, within 72 hours ofter deoth PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. COUNTY b. COUNTY MARYLAND c. LENGTH OF STAY IN 15 c CITY OR TOWN (If auxiliae carparate limits, write RURAL and give nearest tawn) The fow requires that the death certificate be executed within 24 hours off b CITY OR TOWN (if autside comparate limits papers. ,⊆ d STREET ADDRESS e IS RESIDENCE ib hospitol, give street oddress) ON A FARM? filled i NO TX 3. NAME OF carbon 4. DATE Month DECEASED (Type or pant) DEATH IF JNDER 1 YEAR 6. COLOR OR RACE 7. MARRIED NEVER MARRIED AGE (in years IF UNDER 24 HRS n any ev lost birthday) WIDOWED DIVORCED ond 10o USUAL OCCUPAT ON (Give kind of work done 10b. KIND OF BUSINESS OR 12 CITIZEN OF WHAT 1) BIRTHPLACE (County & State, of foreign country), during most of working life, ever | retired) USINESS 13. FATHER'S NAME MOTHER'S MAIDEN NAME Cremation, or removal. INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give wor or dates of service) Colesvilla Nobe 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) INTERVAL BETWEEN signed by the burial-transit p burial, crematic PART I. DEATH WAS CAUSED BY-ONSET AND DEATH Broncho neumon IMMEDIATE CAUSE (a) Page 4 may be retained by the haspital or attending physician. DUE TO Conditions, if any, which gave Carcinoma rise ta immediate causa (o), DUE TO stating the underlying couse os the WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN N PART 1(0) director, page 3 should be detached for use should be filed with the State Dept. of Mealth i NO certificate 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Port I or Port II of item 18.) 20g ACCIDENT WAS UNDERLYING [ OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20d INJURY OCCURRED 20c TIME OF INJURY Month, Day, Year 20e PLACE OF INJURY (Hame, farm, (City or tawn) (County) (State) Haur a.m factory, street, office bldg, etc.) Not While at work FUNERAL DIRECTOR: After 21. I certify that (1) (this haspital) attended the deceased from SEPT 5, 1967, to SEPT 25, 196, that (1) (we) lost saw the deceased alive on 24 SEPT 1967 and that death accurred at 247 PM, from causes and on the date stated above. 220 SIGNATUR 22b. DATE SIGNED -25-67 M.D DIRECTOR PHYS. PHYS 22r. PHYSICIAN'S 22d. ADDRESS nivers' Jr. NAME OF CEMETERY OR CREMATORY 23g. BURIAL, CREMATION, 23b. DATE THEREO! 23d LOCATION (City of Town) (State) (County) Rock Creek Cemetery 250 RECD BY REGISTRAR REMOVAL (Specify) Washington 9 8434 APESzaia Avenue VR A15 (4) 25M 1/67 DATE SEP





MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12641 12632 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE DEP7.V PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) Mintgemer a. COUNTY P.M.3. Page to MARYLAND b CITY OR TOWN ( Loutside comorate limits r LENGTH OF STAY IN 1h write RURAL and a ve nearest town) e. IS RESIDENCE ON A FARM? TUTION (If not in hospital, give street address) Office along with farm YES 3 NAME OF DECEASED DATE Day OF DEATH (Type or print) 19 6 NEVER MARR ED AGE ( n years 7 MARR ED last birthday) Months Davs Hours after death W DOWED 10o USUA, OCC. PATION (Give kind of work done 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT during mast of working life, even if refired) INDUSTRY COUNTRY abame. 13 FATHER S NAME 14 MOTHER'S MAIDEN NAME 72 haurs Unknown 17 INFORMANT 16. SOCIAL SECURITY NO. (Yes, na, or unknown) (If we give war or dates of service A. Allen Howard-Husband any event within 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEE PART I DEATH WAS CAUSED BY esebral-Thrombosis IMMEDIATE CAUSE (a) DUE TO AFterio Sclerosis - Generalized -402175 Canditians, if any which gave shauld be farwarded to use to immediate couse (a). and In DUE TO stating the underlying cause lost 19. WAS AUTOPSY PERFORMED? ar removol, PART II OTHER'S GNIEICANT CONDITIONS CONTRIBLING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION NO X 20g. EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 3 shauld PRIMARY Or CONTRIBUTING CAUSE OF DEATH cremat on, MEDICAL 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20[ (City or town) (County) (State) Not While Hour o.m. foctory, street, affice bldg., etc.) Inspection X Inquity IX. 21 | certify that I took charge of the remains described above, held an Autopsy | ... and in my opinian FUNERAL DIRECTOR: Natural causes 📆. Accident , Spicide death resulted from Homicide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED prior ASSISTANT MEDICAL EXAMINER SIG NATURE DEPUTY MEDICAL EXAMINER Health NAME (Type) Address (Street, city, town, or county) 23c NAME OF CEMETERY OR CREMATORY 230. BURIAL CREMATION. 23d LOCATION (City or Town) 23b DATE THEREOF (County) 0 Nat'l. Memorial Fairfax 24 EUNERA, DIRECTOR Joseph Gawler REC D BY REG STRAR Sanna

Wash

Ave.

VR A15ME (5) 6M 1/67

This certificate shauld be executed within 24 hours after death

please execute the certificate, writing the ward



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 12642 FOR STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH-DEPT. PLACE OF BEATH
a. COUNTY
Montgomery 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) 1. b. COUNTY a. STATE D. C MARYLAND c. CITY OR TOWN (if outside corporete limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits. C. LENGTH OF STAY IN 1b feat write RURAL and give nearest town)
Silver Spring Washington, 2 mths. Depart after ( d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 1805 Monroe St., N. E. 12921 Old Columbia Pike No rs after death. If any del 18. Give Pages 1, 2, and along with form PM3. NAME OF First Middle Last DATE Month Year 25 DECEASED 1967 LESLIE HOYME Sept. GUY (Type or print) DEATH 2 with AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS Last birthday) Months Days Hours Min. 6. COLOR OR RACE DATE OF BIRTH 7. MARRIED NEVER MARRIED Male White WIDOWED 12. CITIZEN OF WHAT 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KND OF BUSINESS OR USUAL OCCUPATION (Give kind of work done in Dustry) 11. BIRTHPLACE (State or foreign country) COUNTRY? Culpeper, Virginia USA Architect Same pages in any 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Charlotte E. Cooper Charles Wm. St. Hoyme should be executed within 24 hou word "pending" in pencil in Item Chief Medical Examiner's Office File pand 17. INFORMANT Address 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unknown) | (If yes give war or dates of service) permit. I Dr.Lucile E. St. Hoyme 1805 Monroe N.E. No INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b)) and (c). ONSET AND DEATH I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (8) burlal-transit | cremation, or | Conditions, If any, which gave rise to immediate **OUE TO** couse (a), stating the used as a l underlying cause last. WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(8) CERTIFICATION INER: This certificate s tificate, writing the w be forwarded to the C PERFORMED? NO N 3 should be agent, prior 1 20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Pert 11 of Item 18.) PRIMARY | or CONTRIBUTING | CAUSE OF DEATH. MEDICAL 20d, INJURY OCCURRED | 20e, PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) 20c. TIME OF INJURY Month, Day, Year factory, street, office bidg., etc.) Hour a.m. Not While at work at work ne certif should b 21. I certify that I took charge of the remains described above, held an Autopsy Inspection V. Inquiry and in my opinion UNERAL DIRECTOR: Health or its design Undetermined manner death resulted from: Natural causes V Sulcide Homicide Accident CHIEF MEDICAL EXAMINER for your **ACTUAL** 22. DATE SIGNED SIGNATURE DEPUTY MEDICAL EXAMINER lease ex irector. etained EXAMINER! Address (Street, city, town, or county) NAME (PYDE) DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY LOCATION (City, town or county) BURIAL, CREMATION. REMOVAL (Specify) re 듁 0 Duria REGISTRAR 25b. LEGISTRAR'S SIGNATURE FUNERAL DIRECTOR 24. VR ALSME (5)

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12635 CERTIFICATE OF DEATH 12644 requires that the deoth certificate be executed within 24 hours after deoth PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) b. COUNTYA a. COUNTY MONTGOMERY MARYLAND signed by the ottending physician and completely filled in by the buriol-transit permit. Then please remove carb<u>an gapers.</u> Pages b CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 15 c CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) VIENNA 24 DAYS BOUNDSDA d STREET ADDRESS d. NAME OF HOSP TAL OR INSTITUTION (If not in haspital, give street address) 126 PATRICK ST., SOUTHEAST ON A FARM & US NAVAL NO NAME OF Middle 4 DATE First Last Manth Year DECEASED (Type or print) RUIHHULL SEPT. 16 67 DEATH buriol, cremotion, or removal, and in any event, IF UNDER 1 YEAR 9 AGE (In years 8. DATE OF BIRTH S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED last bythday) Manths Hours FEMALE CAUC 4 FE. 1929 WIDOWED DIVORCED 12. CITIZEN OF WHAT COUNTRY? USA 100 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSE WIFE 106 KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) INDUSTRY SULLIVAN CITY. TENNESSEE 34. MOTHER'S MAIDEN NAME 13. FATHER S NAME ELIXABETH PATRICK ABNER BREWER 17 INFORMANT 126 PATRICK ST. 16. SOCIAL SECURITY NO IS WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war ar dates of service) S.E. APT. 260 VIENNA, VA 414347495 ROBERT S. HULL 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I DEATH WAS CAUSED BY. ESOPHOGEAL VARICES WITH INTERVAL BETWEEN ONSET AND DEATH GASTROINTESTINAL HEMORRHAGE IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gove CIRRHOSIS OF LIVER (b) rise to immediate cause (a), **DUF TO** stating the underlying couse be detached for use as the State Dept. of Health prior to certificate hos been PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPS) PERFORMED? NO YES X 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part It of item 18) 20a ACCIDENT WAS UNDERLYING . OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL (City or town) (Store) 20c. TIME OF INJURY Manth, Doy, Year 20d INJURY OCCURRED 20e PLACE OF NJURY (Home, form, (County) TO FUNERAL DIRECTOR: After this director, page 3 should be defact should be filed with the State Dep Haur a.m. factory, street, affice bldg., etc.) While at work at work 21. I certify that (1) (this haspital) attended the deceased from 23 AUG., 1967, to 16 SEPT, 1967, that (1) (we) last saw the deceased alive an 16 SEPT. 1967, and that death accurred all 2004M, from causes and on the date stated above. TO HOSPITAL OR ATTEND Page 4 may be retained 22a SIGNATURE 225 DATE SIGNED ATTENDING MED DIRECTOR STAFF PHYS 16 SEPT 1967 M D PHYS 22d. ADDRESS PHYSICIAN'S C. S. CRUMMY, MD NAVAL HOSPITAL, BETHESDA, MD. NAME (Type) 236 DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (Stote) 23a. BUR AL, CREMAT ON, (County) 9-19-67 ARLINGTON NAT"L ARLINGTON FAIRFAX 24. FUNERAL DIRECTOR . A. PUMPHREY ADDRESS REGISTRAR S SIGNATURE 25g. REC D BY REGISTRAR Marley Judge VR A15 (4) 25M 1/67 WISCONCIN AVE. BETHESDA, MD.

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MARYLAND STATE DEPARTMENT OF HEALTH 12636 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12645 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEPT PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY ony delay is 1, 2, and 3 to n PM3. Page e State Department of MARYLAND delay i c. LENGTH OF STAY By 1b. c CITY OR TOWN 11BIRDON d. STREET ADDRESS RESIDENCE (If not in hospital, give street audress) with form ON A FARM? YES DN FS hours ofter death. NAME OF Middle DATE Lost Doy Year DECEASED (Type of print) DEATH 5. SEX 7 MARRIED DATE OF BRITH AGE n years IF UNDER COLOR OR RACE NEVER MARRIED permit. File poges 1 and 2 with lost birthdoy) Months Days WIDOWED DIVORCED ond in ony event within 72 hours after death e certificate, writing the word pending" in pencil in Items should be forwarded to the Chief Medical Examiner's Office KIND OF BUSINESS OR 10o USUAL OCCUPATION (Give kind of work done 12. CITIZEN OF WHAT BIRTHPLACE (State or foreign country) during most of working life, even if retired) COUNTRY? certificate should be executed within 24 Farmer

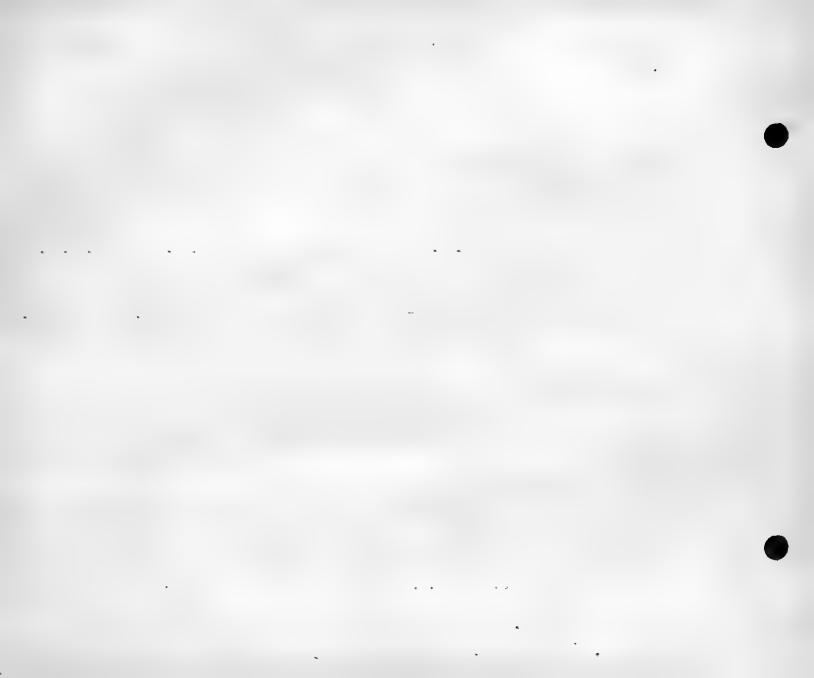
13. FATHER S NAME MOTHER'S MAIDEN NAME Benjamin Hunt Elizabeth B IS WAS DECEASED EVER IN U.S ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT Address (Yes, no exanknown) (If yes give wor or dates of service Howard Hunt - son - same as above INTERVAL BETWEEN ONSET AND DEATH 1B CAUSE OF DEATH (Enter only one couse per ne for (a), (b), and (c)) . ... burial-transit PART I. DEATH WAS CAUSED BY: tonitis. Acute IMMEDIATE CAUSE (o) DUE TO Ruptured Diverticulum of Bladder Recenti Conditions, if ony, which gove rise to immediate couse (o). DUE TO stoting the underlying couse ostatic Hypertrophy with obstruction Inst be used WAS AUTOPSY PERFORMED? PART I OTHER SIGN E (ANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) removal, CERT F CATION NO 20g. EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of tem 1B) 3 should PRIMARY CONTRIBUTING CAUSE OF DEATH MEDICAL 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF NJURY (Home form, (City or town) Hour om factory, street, office bldg. etc.) Not While FUNERAL DIRECTOR: Page 19 of work of work 21 I certify that I taak charge of the remains described abave, held an Autapsy 💢 Inspection X. Inquiry XI. and in my opinian funeral director. Natural causes X Suicide , Undetermined manner deoth resulted fram Accident [ Hamic'de [ CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED SIGNATURE DEPLTY MEDICAL EXAMINER **EXAMINER'S** 7936 Old Geomestown my road for Beth Heolth NAME (Type) BUR AL CREMATION 23b DATE THEREOF 23¢ NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 50 10/4/67 Monocacy Monocacy, Maryland 24 FUNERAL DIRECTOR Rock. 250 REC'D BY REGISTRAR 1967 VR A15ME (5) Rockville, Md. Wheeler Funeral Home 6M 1/67

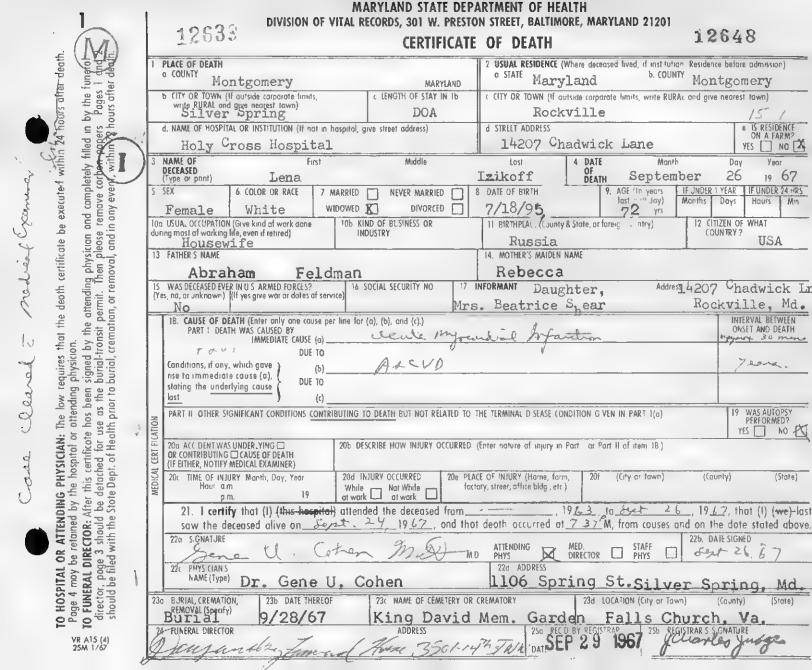


DIVISION OF STATISTICAL RESEARCH AND RECORDS, ION STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where decassed lived, if institution: Residence before admission) a. COUNTYa. STATE b. COUNTY MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give negrest town) c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. NAME OF HOSPITAL OR INSTITUTION (IF d. STREET ADDRESS . IS RESIDENCE ON A FARM? YES NO ete NAME OF First Middle DATE Month Day Year DECEASED OF (Type or print) DEATH 19 67 pon 5. SEX 6. COLOR OR RACE 9. AGE In years | IF UNDER 1 YEAR IF UNDER 24 HRS. 7. MARRIED A NEVER MARRIED certificate be last birthday) Months Hours WIDOWED T physician 1Do. USUAL OCCUPATION (GIRE kind of work @V@ 1Db KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) please 13. FATHER'S NAME MOT .5 attending WAS DECEASED EVER IN U.S. ALMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT removal, Address (Yas, no, or unkown) | (If yas give warer dates of service) the permit. 18. CAUSE OF DEATH |Enter only one cause per line for (a), (b), as INTERVAL BETWEEN been signed by ONSET AND DEATH ō PART I, DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cremation, certificate has been signer use as the burial-transit attending Conditions, if any, which gave rise to immediate ceuse DUE TO burial, (a), stating the underlying causa last. the hospital or PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(8): 19. WAS AUTOPSY 9 PERFORMED? CERTIFICATI prior 6 Vas YES NO EULUL 208. ACCIDENT WAS UNDERLYING 20b. DESCR BE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) After this ce OR CONTRIBUTING CAUSE OF DEATH Health DIRECTOR: After this (IF EITHER, NOTIFY MEDICAL EXAMINER) ATTENDING 20c. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED I 2Da, PLACE OF INJURY (Homa, farm, ! 20f. (City or town) (County) (State) While factory, street, office bldg., etc.) Hour a.m. Not Whila ō at work at work D.m. 21. | certify that (I) (this hospital) attended the deceased from... saw the deceased alive on AM, from the and that death occurred at causes and on the date stated above. OR SIGNATURE DATE ATTENDING STAFF SIGNED death. Page 4 PHYS. DIRECTOR PHYS. HOSPITAL with th M.D. 22c. PHYSICIAN'S 22d. ADDRESS AME (Type) director, g 23a BURIAL, CREMATION, | 23b. DATE THEREOF 23 NAME OF CEMETERY OR CREMATORY MOCATION (City REMOVAL USpacity 24 FLINERAL DIRECTOR'S-SIGNATURE SEI 25b. REGISTRAR'S BY REGISTRAR VR A15 (4) 20M 5-63



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12638 12647 CERTIFICATE OF DEATH papers Pages I and 2 Nin 72 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. COUNTY b. COUNTY OR TITE DING HIVE CMN. The law requires that the death certificate be executed within 24 hours after c LENGTH OF STAY IN 1b E CITY OR TOWN (If adiside carparate limits, write RURAL and give nearest town b. CITY OR TOWN (If outside carparate mits write RURAL and give nearest tawn) .⊑ d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) IS RESIDENCE ON A FARM? filled NO X YES completely fi 4. DATE OF DEATH 3 NAME OF Year DECEASED event (Type or print) 1961 S SEX YEAR AGE (In years IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED last birthday) Hours WIDOWED DIVORCED 52 yrs ottending physicion and permit. Then please rem 10a, USJAL OCCUPATION (Give kind af work done 10b KIND OF BUSINESS OR LI BIRTHPLACE (County & State or lareign country) 12 CITIZEN OF WHAT during most of working life, even if retired) "ashinaton 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME or removal Gertrude Berry 16. SOCIAL SECURITY NO 17. INFORMANT (Yes, no, or unknown) (If yes give war or dates at service) adium Rd Wheaton 77-10-3601 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) buriol-tronsit **DUE TO** Conditions, if any, which gave 3 rise to immediate cause (a), **DUE TO** stating the underlying cause TO FUNERAL DIRECTOR: After this certificate hos been stoched for use as the Dept. of Health prior to 9 WAS A TOPS PERFORMED YES A NO PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION GIVEN IN PART I(o) NO T 20a ACC DENT WAS UNDERLYING [] 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20e PLACE OF INJURY (Hame, form, 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED (City or fown) (County) (State) Haur a.m factory, street, affice bidg , etc.) Nat While 2) I certify that (1) (this haspital) attended the deceased be retained PM, from causes and on the date stated above saw the deceased alive an. and that death accurred at 220 SIGNATURE 226 DATE SIGNED STAFF M.D. DIRECTOR PHYS director, page should be filed 22d ADDRESS NAME (Type) William J. Aud. M.D. 9006 Colesville Rd., Silver Spring, Md. 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23n. BURIAL CREMATION REMOVAL (Specify) Hill Cemetery Suitland 0 1967 l'I anuland 256 REGISTRÁR S SIGNATURE VR A15 (4) 25M 1/67 Silver Spring







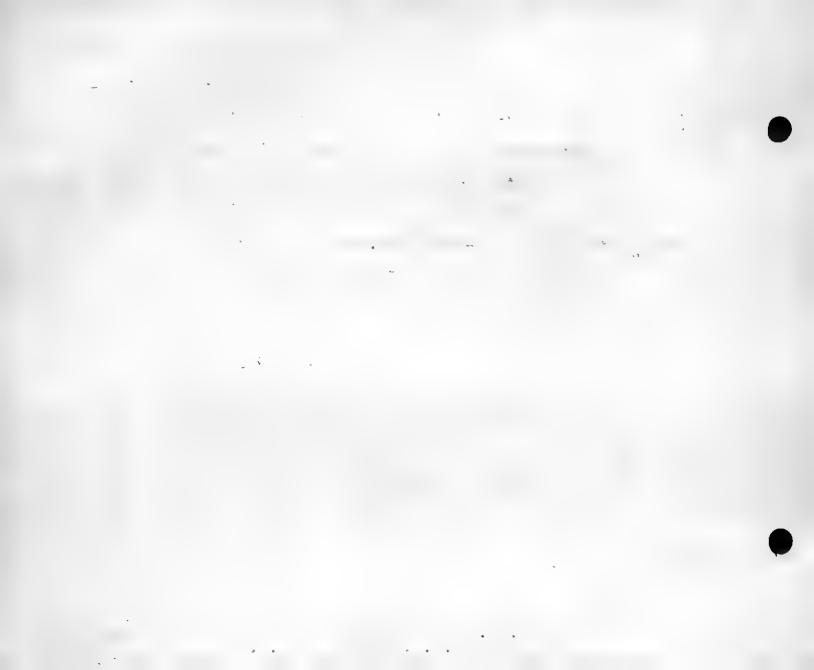
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12649 CERTIFICATE OF DEATH 72540 **OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before-admission) o. COUNTY o STATE **b.** COUNTY MARYLAND b CITY OR TOWN (If autside carparate limits c. LENGTH OF STAY IN 16 c CITY OR TOWN (If gutside corporate limits, write RURAL and give nearest town filled in by the papers. Pag write RURAL and give nearest town d NAME OF HDSPITAL OR INSTITUTION (If not in hospital, give street address) IS RESIDENCE ON A FARM? LUERIDGE YES NO X 3 NAME OF orbon Middle 4 DATE Marth Day Year DECEASED OF DEATH Hiam (Type or print) 19 5 SEX AGE (In years IF UNDER 24 HRS 6. COLOR OR RACE 7 MARRIED IF JNDER 1 YEAR NEVER MARRIED ave, 9 last birthday) Months Hours Dovs ond in ony WIDOWED DIVDRCED X gud 100 USUAL OCCUPATION (Give kind of work done 10b KIND DE BUSINESS OR 11 BIRTHPLACE (County & State, or fareign country) 12 CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? attending physician sermit Then please Enaland notography Photographer
13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME or removal, William Jackson Elspet Pirie WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT 3810 Westford Drive (Yes, na, ar unknown) (If yes give war ar dates of service Mrs. Eileen Yates Kensington, Maryland 217-28-2083 buriol, cremation, 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY: INTERVAL BETWEEN burial-transit ONSET AND DEATH IMMEDIATE CAUSE (o) DUE TO Canditians, if any, which gove (b) rise to immediate couse (a). DUE TO stating the underlying cause Page 4 may be retained by the hospital or attending os the this certificate hos been WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g) NO 20a ACCIDENT WAS JNDERLYING [ 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Port II of Item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, farm, 20c TIME OF N. JRY Month, Dov. Year (City or town) (State) (Caunty) Hour 'a.m. factory, street, affice bldg., etc.) While Nat While at work at work TO FUNERAL DIRECTOR: After 21. I certify that (1) (this hospital) attended the deceased from Samuer . 1967, that (1) (we) last tobact 16 , poge 3 should be filed with the and that death accurred at Dirth, from causes and an the date stated above. 106 saw the deceased alive and 22a SIGNATURE 22b. ATTENDING MED DIRECTOR STAFF PHYS M.D 22c PHYSICIAN'S NAME (Type) director, I 235 DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY BUR AL, CREMATION, 23d LOCATION (City or Town) (County) REMOVAL (Specify) 9t. Lincoln Crematory Prince Georges Co., Maryland Sept. 18.1967 emation BShurse84 34 Georgia Ave. 25a. REC'D BY REG STRAR homas Pumphrey Silver Spring



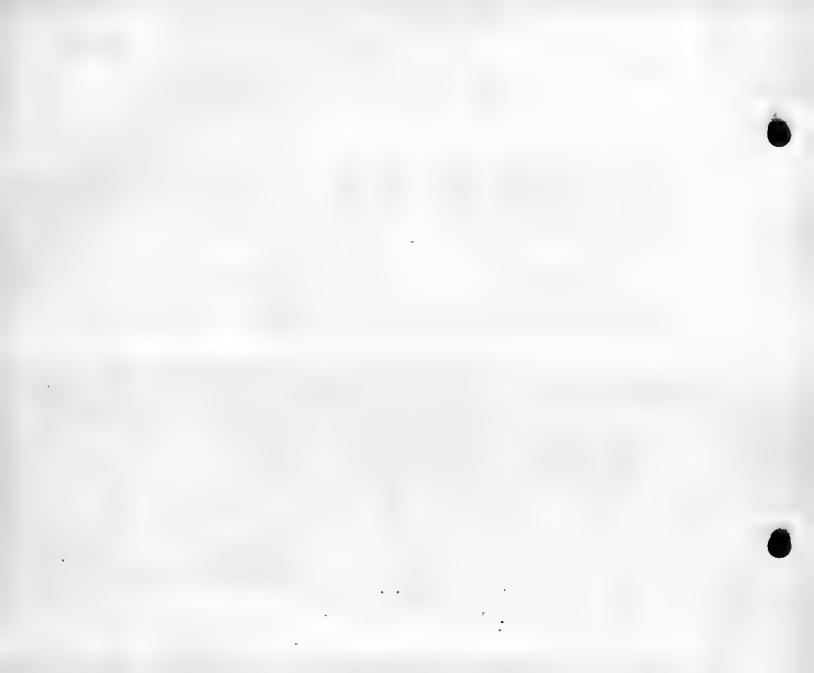
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W, PRESTON STREET, BALTIMORE, MARYLAND 21201 12641 12650 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) Montgomery a. STATE Virginia b. COUNTY MARYLAND b CITY OR TOWN (If autside carparate limits, c CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b. papers. Page Bethesda (Rural) 2 days in by Alexandria d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? filled U.S. Naval Hospital. Bethesda, Md. 2915 Landover Street YES NO DO corbon po NAME OF Middle 4. DATE Last Day Year completely DECEASED (Type or print) OF DEATH JACKSON 1967 Teresa September S SEX 6. COLOR OR RACE IF UNDER 1 IF UNDER 24 HRS. 8 DATE OF BIRTH 9 AGE (In years 7. MARRIED NEVER MARRIED X S Jast birthday) Months MAY 1965 Female Caucasian ond in any WIDOWED DIVORCED pub 10a USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR (it BIRTHPLACE (County & State outgreege country)
Dayton, Onio during most of working life, even if retired) 12 CITIZEN OF WHAT ISACOUNTRY? N/ADUSTRY attending physicion sermit. Then please 13. FATHER 5 NAME 14. MOTHER'S MAIDEN NAME buriol, cremotion, or removal, Elsie BREWER Aubrev G. JACKSON 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yesping or unknown) (If yes give war or dates of service) Address Alexandria, Va. 16. SOCIAL SECURITY NO. 17. INFORMANT N/A Abbrey G. JACKSON 2915 Landover St 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c),) INTERVAL BETWEEN buriol-transit PART I. DEATH WAS CAUSED BY ONSET AND DEATH Constrictive Pericarditis IMMEDIATE CAUSE (a) DUF TO Canditians, if any, which gave (b) rise to immediate cause (a), DUE TO stating the underlying cause Page 4 moy be retoined by the haspital or attending pe aeroched for use as the State Dept. of Health prior to has been last PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? NO 10 FUNERAL DIRECTOR: After this certificate 20a ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER! 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, farm, (C+v or town) (Caunty) (State) Haur a.m factory, street, affice bldg , etc.) Nat While at wark at wark 21. I certify that (1) (this hospital) attended the deceased from 6 Sep 1967 to 8 Sep 1967, that A (we) last and that death accurred at 1:55PM, from causes and on the date stated above. saw the deceased alive an 22a. SIGNATURE 22b. DATE SIGNED 9 Sep 1967 X director, page 3 should be filed v DIRECTOR 22d. ADDRESS 22c. PHYSICIAN S NAME (Type) U.S. Naval Hospitl, Bethesda, Md. D. VAN 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23a. BURIAL, CREMATION. (County) (State) BIMP (Specify) Arlington, 12 Sep 1967 Arlington National Virginia 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS 25g. REC'D BY REGISTRAR Arlington, VR A15 (4) 25M 1/67 IVES FUNERAL HOME 2847 Wilson Blvd. Ocharles Virginia DATSEP



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12651 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE PLACE OF DEATH USUAL RESIDENCE (Where deceased lived if institution Residence before admission) uny detay is a. COUNTY A a STATE Page MARYLAND (If outside cornerate limits, write RURAL and give negrest town) and give negrest town 24 men d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e IS RESIDENCE d "pending" in pencil in Item 18. Give Pages 1, Chief Medical Examiner's Office alang with farm ON A FARM? NO ≯ This certificate should be executed within 24 hours after death NAME OF Muddle Day Year DECEASED DEATH C (Type or print) pages Land 2 with AGE (Hi years IF UNDER 1 YEAR NEVER MARRIED IF UNDER 24 HRS lost berthday) 72 hours after death DIVORCED WIDOWED 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT during most of working life over if retired INDUSTRY COUNTR 4Maps Dept AAA 13 FATHER S NAME File 15 WAS DECEASED EVER IN L.S. ARMED FOR CES?
(Yes, no ar unknown) (Lives a very war or dates of service) INFORMANI 5036 Fu event within B CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c).) PART I DEATH WAS CAUSED BY Coronara IMMEDIATE CAUSE (a) please execute the certificate, writing the ward DHE TO forwarded to the Cardio Vascular Disease any Conditions, if any, which gave rise to immediate cause (a). DUE TO stating the underlying couse be used 19 WAS ALTOPS'
PERFORMED? removal, PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION NO X 20a EXTERNAL CALSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of norm in Part or Part II of item 18.) 3 shauld shauld PRIMARY Or CONTRIBUTING cremation, ar CAUSE OF DEATH MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, farm (City or town) Haur e.m. foctory, street, office bldg, etc.) Not While FUNERAL DIRECTOR: Puge at wark 21 I certify that I took charge of the remains described above, held an Autapsy Inspection X Inquiry X and in my apinian Natural causes death resulted fram Accident Suicide Hamicide Undetermined manner funeral directar be retained CHIFF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER prior SIGNATURE DEPUTY MEDICAL EXAMINER **EXAMINER'S** Heaith Address (Street, city, town, or county) NAME (Type) NAME OF CEMETERY OR CREMATORY 23a BURIAL CREMATION 23h DATE THEREDE 230 LOCATION (City or Town) (County) 0 Burial Baltimore National Baltimore, Maryland Hines Acompany 3 25a REC D BY REGISTRAR 256 REGISTRAR'S SIGNATURE 24 FUNERA, DIRECTOR VR ATSME 14th St. N.W. Washington Dwc SFP 6M 1 6



1	It	em 21 Fi	1m 593 9-2	OF VITAL R	ARYI Ecor	LAND STATE DEPA RDS, 301 W. PRESTO	N ST	M <b>ENT OF HEAI</b> REET, BALTIMOI	lth Re. Mai	RYLAND 21201			
		1254				CERTIFICATE			,		126	552	2
hours after death. in by the funeral irs. Pages 1 and 2 2 hours after death.		PLACE OF DEATH o. COUNTY MO	ntgomery			MARYLAND	٥	STATE Virg	inia	osed lived, if institution b COUNT	1		fan.
aurs af	L	write RURAL and Bethesd	autside comarate limits give nearest town) a.	5,		ength of stay in 16 299 days		Alexandr:		rate limits, write RURA	L and give r		20
Illed in papers	T	he Clinic	al Center,			, Maryland		treet address 3822 Inga	lls /	Avenue			IS RESIDENCE ON A FARM? IS NO X
e executed within 24 had campletally filled in remave carban papers.	Ł	NAME OF DECEASED (Type or print) SEX	Susan 6. COLOR OR RACE	7. MARRIED		Middle Diane NEVER MARRIED X 8	J	Last ESSIE IF OF BIRTH	4 DATE OF DEAT	September	r If JNDER 1 Y	Doy 13	Year 19 67 IF UNDER 24 HRS.
e execut and cam remave any ev		Female	White	WIDOWED	ND OF		12	August 19 BIRTHPLACE (County 8		lost birthday)		)ays	Hours Min
icate bo Isocian ( please		ing mast of working to Student FATHER'S NAME	(Give kind of work done ite, even if retired)	Į IN	DUSTR	Y	1	Virginia Mother's Malden NA			(OUI	ITRY?	USA
h certif ing phy Then remavo	15	WAS DECEASED EVER	D. Jessie	16	SOCIAL	. SECURITY NO 17 II	NFOR	Mary E.		es L Reco <b>rd</b> idress			
he deat attend jan, or	(Y)	No	(If yes give wor or dotes of ATH (Enter only one cou	1	lone	e The	C.	linical Ce	ente	r, Bethesda	a, Mai	INTER	VAL BETWEEN
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the haspital ar attending physician.  TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletally filled in by the funeral director, page 3 should be detached far use as the burial-transit permit. Then please remave carbon papers. Pages 1 and 2 should be filled with the State Dept. af Health priar ta burial, crematian, or remaval, and in any event.		PART I. DEAT  Conditions, if any, rise to immediate stating the under	couse (a).	(o)	lia	ctasis and p gnosed disea ess, hypomag	ıse	characte	rize	d by		3 ONSE	ears
. The law r attendin e has bee use as th	ATION	PART II, OTHER SIG		(c)ONTRIBUTING 1	O DEA	NTH BUT NOT RELATED TO T	HE TE	RMINAL D SEASE CONE	OITION G	VEN IN PART 1(o)			VAS AUTOPSY ERFORMED?
YSICIAN: aspital a certificat thed far ot. of Hec	AL CERTIFICATION	20o ACCIDENT WAS OR CONTRIBUTING I (IF EITHER, NOTIFY A	□ CAUSE OF DEATH MEDICAL EXAMINER)			HOW INJURY OCCURRED (		. ,				-	
ING PH oy the h ter this be detect itate Dep	MEDICAL	Haur o.m p.cr	1. 19	While at war		at wark L		INTURY (Hame, farm, reet, affice bldg , etc.)		(City or town)	(Coun		(State)
R ATTEND retained b ECTOR: Aft 3 should b with the S		saw the de	1 1/-	eptembe	r i	he deceased fromNo 1319_67, and that	A	TTENDING - 1		M	22b. DATI	SIGNEL	
SPITAL OF The SPITAL OF THE SPITAL OF SPITE OF THE SPITE		22c PHYSICIAN S NAME (Type)	Paul W.			M.D.	]	22d ADDRESS The Institutes	Cli of	nical Cent Health, Bo	ter, l	lati	onal
TO HOS Page 1 TO FUN directs		REMOVAL (Specify)	그 무슨없네.	1,6	11.0	MAME OF CEMETERY OR I		L.PMF.TE	i v	Chathan		aunty)	(Stote)
VR A15 (4) 25M 1/67	Į.	Ver by	heatley	Funera	3 1	Hone, Alex	• • \	ZSG RECD	EP 1	8 1967	Clar	Les	Judge

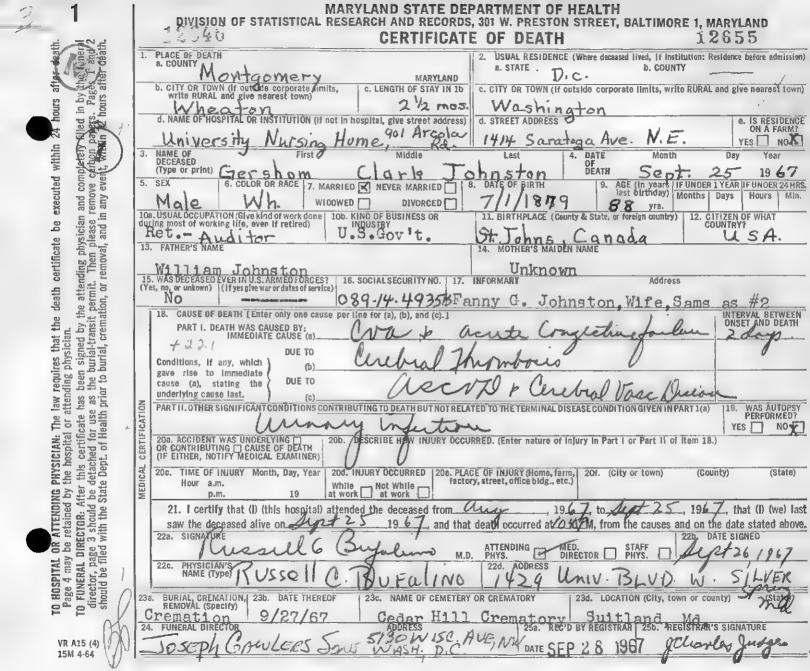


DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item #9 Film #0392 9219202 ph CERTIFICATE 12653 PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. COUNTY o STATE MARYLAND b. CITY OR TOWN (If outside corporate limit. c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town write RURAL and give hearest town d. STREET ADDRESS IS RESIDENCE ON A FARM? OR INSTITUTION (If not a hospitol, give street address) 5 -NO 🔀 NAME OF Middle Year DECEASED OF (Type or pont) 1au DEATH 19 6 IF UNDER 1 YEAR 6. COLOR OR RACE AGE (In years IF UNDER 24 HR 7. MARRIED NEVER MARRIED Months Hnurs remay n any While WIDOWED IX DIVORCED TOP KIND OF BUSINESS OR 10o JSUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT ease during most of working life, even if retired)
Salesman COUNTRY? and Lockwood Dental 13. FATHER'S NAME Lab. 14. MOTHER'S MAIDEN NAME 0 ar remaval, attending physoermit. Then s William Johnson Nora Wilson 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address (Yes, no, or unknown) (If yes give wor or dates of service) Mrs. Susan C. Muschlitz (above ad cremation, 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), one (c) dress) INTERVAL BETWEEN (Sister) transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: signed by burial-trans IMMEDIATE CAUSE (o) **10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires the Page 4 may be retained by the haspital ar attending physician. DUE TO me carcinoma burial, Conditions, if ony, which gove rise to immediate couse (a). DUE TO stoting the underlying couse O FUNERAL DIRECTOR: After this certificate has been PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(c) WAS AUTOPSY PERFORMED? for use Health NO X 20b, DESCRIBE HOW INJURY OCCURRED. (Enter notice of enjury in Port I or Port II of 20o. ACC. DENT WAS UNDERLYING [ OR CONTRIBUTING CAUSE OF DEATH detached te Dept. af (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or fown) (County) (Stote) Hour o.m. While factory, street, office bldg., etc.) ot work 21. I certify that (I) (this haspital) attended the deceased from 196/, that (1) (we) last 67, and that death accurred at 500M, from causes and on the date stated obove saw the deceased alive on 226 DATES GNED 22o. SIGNATURE director, page 3 should be filed v M.D. PHYS DIRECTOR PHYS 22c. PHYSICIAN'S NAME (Type) 230. BURIAL, CREMATION DATE THEREOF NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (Stote) 12/67 FREMOVAL (Specify) Ivy Hall Cometery Upperville, 24 FUNERAL DIRECTOR Nalley's Funeral ADDRESS Mt. Rainier 250. REC'D BY REGISTRAR Home Inc. Maryland 1011 CCD 15 2Sb. REGISTRAR'S SIGNATURE VR A15 (4) 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12845 CERTIFICATE OF DEATH 12654 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. COUNTY o. STATE b. COUNTY Montgomery MARYLAND Maryland Montgomery c EITY OR TOWN (If autside carparate imits, write RURAL and give pearest town) b. CITY OR TOWN (If outside corporate limits c. LENGTH OF STAY IN 15 write RURAL and give nearest town) Gaithersburg Gaithersburg d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) S RESIDENCE ON A FARM? d. STREET ADDRESS RFD #3 Box 252 NO X burial, cremation, or removal, and in ony event, within Box 252 YES requires that the death certificate be executed wathin 3. NAME OF Middle DATE Last Month Day Year DECEASED Elmer (Type or pnrit) Johnson 30. DEATH September IF UNDER I YEAR I IF UNDER 24 HRS 5 SEX AGE (In years 6 COLOR OR RACE 7 MARRIED B. DATE OF BIRTH NEVER MARRIED remove last birthday) Manths White Days Hours Male WIDOWED DIVORCED Sept 3, 1898 10o. USUAL OCCUPATION (G-ve kind of work done 70b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during mast of working life, even if retired) COUNTRYS attending physicion overmit. Then please INDUSTRY Well Digger Oklahoma 13. FATHER S NAME 14. MOTHER'S MAIDEN NAME Laura A. Foster Joseph E. Johnson WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, na, ar unknown) {If yes give war or dates af service 441-03-0764 Richard N. Johnson- same item "2 -Son YAS 18 CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c)) PART ( DEATH WAS CAUSED BY al-trons t IMMEDIATE CAUSE (o) DUE TO signed bur al-tr Conditions, if any, which gave rise to immediate cause (a), DUE TO stating the underlying cause ed for use os the of Health prior to last PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g) 19. WAS AUTOPSY PERFORMED? NO Z PHYSICIAN: 20g ACCIDENT WAS JINDERLYING 206 DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part 1 or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH defoched (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Day Year 20d INJURY OCCURRED 20e PLACE OF NJURY (Home, form, 20f (City or town) (County) (Stote) Hour a.m factory, street, affice bidg, etc.) While Not While at wark FUNERAL DIRECTOR: After at work 21. I certify that (1) (this haspital) attended the deceased fram 19\_\_\_\_, that (1) (we) last O HOSPITAL OR ATTEND Page 4 may be retained 2, and that death accurred at 45. M. fram causes and an the date stated above saw the deceased alive an\_\_\_ 220 SGNATURE 22b DATE SIGNED **ATTENDING** 9-30-6 DIRECTOR PHYS PHYS. director, page : 220. ADDRESS 105 Russel Ave., Gaithersburg, 22c/PHYSICIAN'S NAME (Type) Jack Schumacher 230 BURIAL, CREMATION 23c NAME OF CEMETERY OR CREMATORY Cedar Hill 23d .OCATION (City or Town)
Prince George 23b. DATE THEREOF (County) CREMOVAL Specify n 10/4/67 Rock 250. REC'D BY REGISTRAR 24 FUNERAL DIRECTOR VR A15 (4) 1967 Tyson Wheeler Funeral Home 25M 1/67





MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12656 1284 CERTIFICATE OF DEATH PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission o. COUNTY o. STATE b. COUNTY Montgomery Maryland MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda (rural) c LENGTH OF STAY IN 1b. c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours, 13 days Lexington Park d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS IS RESIDENCE ON A FARM? Route 1, Box 433, Naval Hospital NO Se YES NAME OF remove Karban Lost 4 DATE Month Dov Уеаг DECEASED JONES (Type or pant) Lorraine Irene September 19 67 DEATH 6. COLOR OR RACE 8 DATE OF BIRTH AGE (In years IF UNDER 24 HRS 7 MARRIED NEVER MARRIED burial, crematian, ar remaval, and in any ev lost birthdoy) Female Cauc WIDOWED DIVORCED June 16, 1934 100 USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fareign country) 12 CITIZEN OF WHAT during most of working life, even if retired)

N/A (housewife) COUNTRY? Baltimore, Maryland
14. MOTHERS MAIDEN NAME USA 13. FATHER'S NAME James M. Drury Eva Dubroski 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service 16. SOCIAL SECURITY NO. Lexington de Park. Md. Lot 53 AZ1 Richard E. Jones, USN, Route 1, Box No 18. CAUSE OF DEATH (Enter only one cause per fine for (a), (b), and (c) ) signed by the burial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY Acute bilateral pyelonephritis IMMEDIATE CAUSE (o) Secondary to radiation cystitis with obstruction DUE TO ureteral vesicle junction bilateral. Conditions, if ony, which gove rise to immediate couse (a). DUE TO stoting the underlying couse Secondary to carcinoma of cervix WAS AUTOPS PERFORMED?
YES X NO has PART H. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(c) CERTIFICATION 200 ACC DENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Part II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d INJURY OCCURRED 20c. TIME OF INJURY Month, Doy, Yeer 20e. PLACE OF INJURY (Home, farm, (City or town) (County) (Stote) factory, street, office bldg., etc.) of work of work O FUNERAL DIRECTOR: After 21. I certify that (IX(this haspital) attended the deceased from Aug. 24 , 19 67, to Sept. 6 , 1967, that (1) (we) last 19 67, and that death accurred at 700AM, from causes and on the date stated above. the deceased alive an Sept. 6 226 DATE S GNED 6 Sept. 1967 DIRECTOR director, page 3 shauld be filed 22d. ADDRESS PHYSICIAN S NAME (Type) Naval Hospital, Bethesda, Maryland Cones M. D Lawrence. 23c NAME OF CEMETERY OR CREMATORY 23b DATE THEREOF 23d. LOCATION (City or Town) 23o. BUR AL, CREMATION Sept. 10,196 Loudon Park National Cemetery, Baltimore, Md. 24. FUNERAL DIRECTOR Mattingly Funeral Homeress VR A15 (4) Leonardtown, Maryland



# <b>1</b>	Items 18&21 Film 394 MARYLAND STATE DEPARTMENT OF HEALTH  11-14-67 ams division of vital records, 301 W. Preston Street, Baltimore, Maryland 21201	
FOR STATE	MEDICAL EXAMINER'S CERTIFICATE OF DEATH	657
HEALTH DEPT.	ma Po to a	
	1. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceosed lived, if institution Reside a COUNTY b COUNTY	nce befare admission)
# B   B   B	manigomera Maryland 1), C.	
and	b CITY OR TOWN (If autside carparate limits, write RURAL and give negrect town), (LENGTH OF STAY IN 1b) (CITY OR TOWN (If autside carparate limits, write RURAL and give	ve nearest lawn)
ff any delay is 1, 2, and 3 to rm PM3. Page	10 Krma tark Washington	*
P E B	d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address)  d STREET ADDRESS	e IS RESIDENCE ON A FARM?
N 0 0	Wash San + Hospital 1/830-17 St. n.w. 4	O/ YES NO SA
death with the Sta	3 NAME OF DECEASED And Andrew Last 4 DATE Month	Day Year
5 8 8 VE	(Type or pnnt) MICHELL S JONES DEATH 9	10 1961
afte after a solution and a solutio	last buthdow) Manths	Days Hours Men
hours Item 13 Office 1 and 2	male while whome I stored I 1-16-49 18 yrs	
thours Item I. Office Iond2	10a USUAL OCCUPAT ON (Give kind of work done during roos) of warking life, leven if retired)  10b KIND OF BUSINESS OR 11 BIRTHPLACE (State or fareign country)  (c)	ITIZEN OF WHAT OUNTRY &
hin 24 nol in niner s pages urs afte		OUNTRY 3
within pencil caminel le page	13 FATHER'S NAME	
f win in pe Exar File 2 ho	Hewton Jones marjorie Clyburn	
ir i	15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Address (Yes, ng. grynknown) [If yes give wanter dates at service)	· ~ /
id be executed within 24 hours after death rd "pending" in pencil in Item 18. Give Page Ch et Medical Examiner's Office along with fitansit permit. File pages lond 2 with the Statevent within 72 hours after death.	NO Mergaret L. Jones Clexander	0 / 0
f M	18 CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY	ONSET AND DEATH
	. IMMEDIATE CAUSE (a) MULTUIPLE EXCIPENCE BRUIL IPACTURES	
shauld be ward or the Che Che Che Che Che Che Che Che Che C	Conditions, if any, which gave ) the incurred in puto accident	
the water to the to the to the in any in any	nse to immediate cause (a),	
f cate ing th rded to as a	staling the underlying cause (1)	
	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	Lin was allroney
EXAMINER: This certi ute the certificate, writ age 4 should be farwar your files Page 3 shauld be used crematian, ar remaval,	12   PART II OTOEK SIGNIFICAN CONDITIONS CON'R BUTING TO DEATH BUT NOT RECUTED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0)	19 WAS AUTOPSY PERFORMED?
This icate be for	200 EXTERNAL CAUSE WAS 20th DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 of item .8)	YES NO [
NER: T certifica hould b tles shauld an, ar ru	PRIMARY-BOT CONTRIBUTING	2 caldowt
INER: he certiff should files 3 should tian, ar	S 20c TIME OF INJURY Month, Day, Year 20d INJURY DCCURRED 20e PLACE OF IN.URY (Harne, Jarm, 1 20f (Gity or town)) (Co	ounty) (State)
the the second the sec	While — Not While — factory, street affice bidg etc.)	1,
MEDICAL EXAMINER: This please execute the certificate, director Page 4 should be foreigned for your files.  DIRECTOR: Page 3 should be to birector to buriel, cremation, or remo	at work di work	
- 25 G - 5 G	21. I certify that I taak charge of the remains described above, held an Autapsy Inspection. Inquiry	and in my apinian
brcal se exector Pertor	death resulted fram: Natural causes, Accident, Suicide, Hamicide, Undetermined manner	
Medire direction to	ACTUAL  SIGNATURE  CHIEF MEDICAL EXAMINER  M.D. ASSISTANT MEDICAL EXAM NER	22. DATE SIGNED
UTY MEDICAL  Juy, please executed director Please retained for RAL DIRECTOR.  prior to burial.		7
TO DEPUTY MEDICAL EXAM necessary, please execute the funeral director Page 4 5 may be retained for your TO FUNERAL DIRECTOR: Page Health prior to burial, crema	NAME (Type)  Addings Estreet, city-nowe-exclaunty)	YON.
O DEPI necesso the fun 5 may 0 FUNE Health	236 BURIAL, CREMATION, 236 DATE THEREOF 236 NAME OF CENTERY OR CREMATORY 236 LOCATION (City of Town)	(County) (Mate)
5 = = N 5 =	Burial Sept 13, 1967 Ft Lincoln Cemetery Colmar Panor Pro	11 21
MB ATEMS (EV.	24 FILINERAL DIRECTOR ADDRESS 1250 PEC DE POR DECENTRADO	SIGNATURE
VR A15ME (5)	F. Gasch's Sons Hyattsville, Md. SEP 14 1967 Policy	Co Judona



. 1	It	tems 18&21 Film 394 MARYLAND STATE DEPARTMENT OF HEALTH -14-67 ams Division of Vital RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	
/ FOR STATE		12043 MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
FOR STATE HEALTH DERT.	-	MEDICAL EXAMINER & CERTIFICATE OF DEATH	
		PLACE OF DEATH  a. COUNTY  a. COUNTY  b. COUNTY  b. COUNTY	·
any delay is ond 3 to my PM3 Page	12	b CITY OR TOWN If quiside corporate limits   C LENGTH OF STAY IN 1b   C CITY OR TOWN If quiside corporate limits, write RURAL and drive nearest fown)	7-
Mand de		Twite RURAL and give nearest town	/
I, 2, on PM		d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address)  d STREET ADDRESS  e IS RE ON A	SIDENCE FARM?
ith form		Wash Sam + Hospital 1/42/5 Londan Lane 155	NO X
s certificate shauld be executed within 24 haurs after death. If e., writing the word "pending" in pencil in Item 18. Give Pages 1, forwarded to the Chief Medical Examiner's Office along with farm used as a burial-transit permit. File pages 1 and 2 with the State Denaval, and in any event within 72 haurs after death.		NAME OF DECEASED (Type or print)  NIME OF DECEASED (Type or print)  NIME OF DESTRUCTION OF DEATH OF DEATH OF DEATH OF DEATH	Year 1
ffer Giv ang ith th		SEX - 6. COLOR OR RACE   7 MARRIED   NEVER MARRIED   8 DAY OF BIRTH   9. AGE (In year)   IF JNDER I YEAR   IF UND	DER 24 HRS
18. 18. 2 w 2 m	4	emale Wibite WIDOWED DIVORCED	
hau Item Offic I and	10a dus	s USUAL OCCUPATION (Give kind of work done interior) 10b KIND OF BUSINESS OR II BIRTHPLACE (State or foreign country) 12 (ITIZEN OF WHAT the most of work no like even if retired) 10b KIND OF BUSINESS OR Washington, D.C. U.S.A.	
24 in er's er's afte afte		FATHER'S NAME    Montgue	
nthin pencil pm.in page		William R. Jones Wirainia C. Cox	
Exc File 72 h	15	WAS DECEASED EVER IN U.S. ARMED FORCES? 18. SOCIAL SECURITY NO 17 INFORMANT Address	
ecute ing " dica dica trin	116	es (co. or unknown) (If yes give wor or dates of set/ice) 218-54-8437   William R. Jones - Father - same its	em #2
exe endi f Me iit pe it wit		IN CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c) PART I DEATH WAS CAUSED BY Multiple extreme fractures of skull ONSET AND	BETWEEN D DEATH
d be d 'r Chie trans		PART DEATH WAS (AUSED BY IMMEDIATE CAUSE (0) Multiple, extreme fractures of skull OUSET AND DUE TO	
wor wor the rrial-		(angitions, if ony, which gave ) (as incommed in suite accident	
the state of the in c		rise to immediate cause (a), stating the underlying cause DUE TO	
ifica ting tradec radec as and		(c)	
MEDICAL EXAMINER: This certificate shauld be executed within 24 haurs after de please execute the certificate, writing the word "pending" in pencil in Item 18. Give I directar. Page 4 shauld be forwarded to the Chief Medical Examiner's Office along wertained for your files.  DIRECTOR: Page 3 shauld be used as a burial-transit permit. File pages 1 and 2 with the rit to burial, crematian, or remayal, and in any event within 72 haurs after death.	N	PART II OTHER'S CHIFTCANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(0)  19 WAS AI PERFORM YES AL	RMED?
INER: This e certificate, should be files. 3 should be tian, or remotion, or remoti	CERTIFICAT	20g. EXTERNAL CAUSE WAS 20g. DESCRIBE HOW INLIRY OCCURRED. (Faler nature of price in Part Lar Part II or Part	NU
EXAMINER: This use the certificate toge 4 shauld be your files. Page 3 shauld be crematian, or rem	CERT	PRIMARY EL OF CONTRIBUTING   CAUSE OF DEATH	
NNER shaul shaul files.	MEDICAL	20c TIME OF INTIRY Month Day Year 20d INTIRY OCCURRED 20e PLACE OF NIVRY (Hame form 20f (Gity or to An) (County)	(Stote)
L EXAMINER: ecute the cert recute the cert Page 4 snauld ar your files. R: Page 3 shau R: Page 3 shau I, crematian, o	¥	33 hour am 9-10 1967 of While of work of work to towark of work of two	Med
cal E executor. Par d far Tron: F		21 i certify that I took charge af the remains described above, held an Autapsy Inspection Inquiry , and in m	y opinian
MEDICA elease ex director. etained to burit		death resulted fram: Natural causes, Accident, Suicide, Homicide, Undetermined manner	
ITY MEDICAL ENDING, please executed director. Page retained for RAL DIRECTOR: prior to buriel, o		SIGNATURE M.D. ASSISTANT MEDICAL EXAMINER 22. DA	TE SIGNED
UTY any, nera be be pric		EXAMINER'S TO 4 & 5 R & 3 C & 3 C & 5 C &	
TO DEPUTY MEDICAL EXAM necessary, please execute th the funeral directar. Page 4 5 may be retained for your TO FUNERAL DIRECTOR: Page Health prior to burial, crema	73,	NAME (Type) Address (Street, city, town, or county)  BUR AL CREMATION, 23b DATE THEREOF (23c NAME OF CEMETERY OR CREMATION) 23d LOCATION (City or Town) (County)	(State)
5 = = 5 +	231	Burial (REMATION, 236 Date THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (Gry or Town) (County)  Burial Prince George Co., Mc	
VR A15ME (5)		4. FUNERAL DIRECTOR 250 REC'D BY REGISTRAR 250 REGISTRAR'S SIGNATURE	140
6M 1/67	L	Tyson Wheeler Funeral Home 1331 Rock Pike Rockville, Mary 144 n SEP 13 1967 gallarles Ju	0



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12650 12659 CERTIFICATE OF DEATH **OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours ofter death be retained by the haspital or oftending physicion. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a county Montgomery o State Michigan b. COUNTY MARYLAND Mason b. (ITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda c LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give neatest fawn) 53 Davs Ludington d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress 20014) d STREET ADDRESS IS RESIDENCE ON A FARM? The Clinical Center, Bethesda, Maryland Route 2. Dicker Road NO X carbon 4. DATE Lost Month Year DECEASED Peter (MMN) Jorgensen September 8 1967 (Type or pant) DEATH F UNDER 24 HRS SEX 6. COLOR OR RACE 8 DATE OF BIRTH AGE (In years IF UNDER I YEAR 7 MARRIED NEVER MARRIED lost birthday) Months Hours Male White WIDOWED DIVORCED 9 May 1908 10o USUAL OCCUPATION (Give kind of work done 11 BIRTHPLACE (County & Stote, or foreign country) 12 CITIZEN OF WHAT 10b. KIND OF BUSINESS OR Shipping during most of working life, even if retired) (F1Lot) American Seaman COUNTRY? Denmark USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Hans Jorgensen Anna Kundsen IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT The Medical Reconder, The Clinical (Yes, no, or unknown) (If yes give wor or dotes of service) 711-01-8379 Center, Bethesda, Maryland 20014 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c))
PART 1. DEATH WAS CAUSED BY. INTERVAL BETWEEN After this certificate has been signed by the be detached for use as the bur al-trons to State Dept. of Health prior to burial, creman PINSET AND DEATH Septic Shock IMMEDIATE CAUSE (o) DUE TO Soft Tissue & Probable bone infection Conditions, if any, which gove 5 Davs rise to immediate couse (a). 50 Days DUE TO Blast crisis stating the underlying couse Chronic Myelogenous Leukemia/ 2 Years 19. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) YES [X] NO [ 20o ACCIDENT WAS UNDERLYING [ 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or fown) (County) (Stote) Not While foctory, street, office bldg., etc.) at work at work DIRECTOR: After 21 I certify that (\*) (this haspital) attended the deceased from 17 July , 1967, to 8 September 967, that (\*) (we) lost saw the deceased alive an 8 September 1967, and that death accurred at 6:30M, from causes and an the date stated above TO FUNERAL DIRECTOR: Af-director, page 3 should be should be filed with the Si 22g. SIGNATURE 22b DATE SIGNED STAFF X DIRECTOR . 8 Sept. 1967 PHYS. 22d. ADDRESS The Clinical Center, National 22c. PHYSICIAN'S O HOSPITAL Charles M. Haskell, MD. NAME (Type) Institutes of Health, Bethesda, Md. 2001/4 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City of Town) 230 BURIAL, CREMATION 23b DATE THEREOF (County) Juriat Gransit 9-9-67 Ludington, Michigan Lakeview Cemetery 250 REC'D BY REGISTRAR **ADDRESS** 2Sb REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR VR A15 (4) 25M 1/67 PUMPHREY, Bethesda, Maryland



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 12660 The law requires that the death certificate be executed within 24 haurs after death. and PLACE OF DEATH the funeral 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) emave carban papers. Pages 1 and any event, within 72 haurs after deg COUNTY o. STATE b. COUNTY MARYLAND mone b CITY OR TOWN (If outside corporate limits, CLENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest tawn) saus RO ,⊆ d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) B IS RESIDENCE d STREET ADDRESS filled YES NAME OF emave carban 4 DATE Doy Year DECEASED OF DEATH (Type or print) 19 SEX 7. MARRIED **NEVER MARRIED** AGE (in years IF UNDER 1 YEAR IF UNDER 24 HR burthday) Months Doys Hours WIDOWED DIVORCED pung 100 USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT (County & Stote, or foreign country) during most of working life, even if retired ~INDUSTRY COUNTRY? 13. FATHER'S NAME signed by the attending physical-transit permit. Then be burial, cremation, or remayal 14. MOTHER'S MAIDEN NAME 17 INFORMANT (If yes give wor or dotes of service (Yes, no. or unknown) 18. CAUSE OF DEATH (Enter only one couse per line for (a). ond (r).) PART I DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (a) **ro Hospital OR ATTENDING PHYSICIAN:** The faw requires the Page 4 may be retained by the haspital or attending physician. **DUE TO** Conditions, if ony, which gove ) nse to immediate couse (a), DUE TO stoting the underlying couse TO FUNERAL DIRECTOR: After this certificate has been State Dept. af Health prior to 20 WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) for use NO 200 ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 1 of Hem. 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 3 20c TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Q3W Hour to m. While Not While foctory, street, office bldg, etc.) of work L ot work 21. 1 certify that (!) (this hospital) attended the deceased from director, page 3 should should be filed with the 304M, from causes and an the date stated obove. saw the deceased alive an and that death occurred at DATE SIGNED 220. SIGNATURE. 22d ADDRESS 22c PHYSICIAN'S 0820 Ja. Ave. 236 DATE THEREOF 230 BURIAL, CREMATION 23d LOCATION (City or Town (Stote) PEMOVAL (Specify) Md 24. FUNERAL DIRECTOR 250 REC'D BY REGISTRAR 2Sb VR A15 [4] 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12652 12661 CERTIFICATE OF DEATH death. I. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. COUNTY b.\_COUNTY ONTGOME n 72 haurs after MARYLAND PRINCE GEBRGE Pages b CITY OR TOWN (If outs de corporete limits, write RURAL and give necrest town), C LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town) requires that the death certificate be executed within 24 haurs in by AKOM d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) papers. d STREET ADDRESS e IS RESIDENCE th ON A FARM? and campletely filled SANITARIUM 0 NO X NAME OF 4 DATE Year DECEASED (Type or print) LBAUGH OF event, 6 DEATH 19 6. COLOR OR RACE 7. MARRIED AGE (In years IF UNDER IF UNDER 24 HRS NEVER MARRIED remove lost birthdoy) Months Doys Hours burial-transit permit. Then please remo burial, crematian, ar removal, and in any WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11 BIRTHPLACE (County & State, or foreign country) during most of working) fe, even if retired) ouse wite 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME signed by the attending phy burial-transit permit. Then 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, na, ar unknawn) (If yes give war or dates of service PECORDS IB. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).

PART I DEATH WAS (AUSED BY INTERVAL BETWEEN ONSEJ AND DEATH IMMEDIATE CAUSE (o) attending physician. DUE TO Conditions, if any, which gave rise to immediate cause (a). DUE TO stating the underlying cause O FUNERAL DIRECTOR: After this certificate has been director, page 3 shauld be detached far use as the shauld be filed with the State Dept. af Health priar ta ATTENDING PHYSICIAN: The law lost. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (g) 19. WAS AUTOPSY PERFORMED? NO Page 4 may be retained by the hospital ar 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I at Part II at Item 18.) 20a. ACCIDENT WAS UNDERLYING [] OR CONTRIBUTING III CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20c TIME OF N.JRY Manth, Day, Year 20e PLACE OF IN. JRY (Home, form (City or fown) (County) (State) Hauria.m. factory, street, affice bldg., etc.) Not While at wark at work 21 I certify that (I) (this haspital) attended the deceased fram That (1) (we) lost director, page 3 shauld , and that death occurred a saw the deceased alive an fram couses and an the date stated above 22a. SIGNATURE 22b. DATE SIGNED ATTENDING M.D. PHYS DIRECTOR 22c PHYSICIAN'S 22d ADDRESS NAME (Type) 23c NAME OF CEMETERY OR CREMATORY 23d 10CATON (City or Town)
Lanham Pro Geo 230 BURIAL CREMATION. 23b DATE THEREOF (County) (Stote) REMOVAL (Specify) Lanham Sept 16, 1967 Whitfield Cemetery Burial 24. FUNERAL DIRECTOR 2Sq. REC'D BY REGISTRAR Hyattsville, Md. 2Sb. REGISTRAR'S SIGNATURE F. Gasch's Sons VR A15 (4) 25M 1/67



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12853 12662 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEEL PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) 2, and 3 to PM3. Poge MARYLAND C LENGTH OF STAY IN 16 COTY outside corporated in ts, write RURAL and give nearest town ofter ( d NAME OF HOSPITAL OR spital give street address) d STREET ADDRESS IS RES DENC ON A FARM in Item 18. Give Pages 1, r's Office along with form hours YES 24 hours after deoth. NAME OF First Lost 4. DATE Year DECEASED OF DEATH 9 AGE (In years IF UNDER 24 HRS NEVER MARRIED Months Doys Hours DIVORCED OCCUPATION (Give kind of work done K ND OF BUSINESS OR State or foreign country) 12 CIT ZEN, OF WHAT Own Home Examiner's pencil 13 EATHER'S NAME 14. MOTHER'S be executed within ⊑ puo AS DECEASED EVER IN L S ARMED FORCES? 16 SOC AL SECURITY NO no, or unknown) (If yes give wor or dates of service) removal. 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) NIERVA, BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY Acute coronary thrombosis 5 MMEDIATE CAUSE (o) s certif cate should et KE1. 1 cremotian, DUE TO Conditions if any, which gove forwarded to rise to immediate couse (a), DUE TO stoting the underlying couse Coronary artery heart disease rost burial, PART IS OTHER 5 GNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINA, DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPS1 PERFORMED? NO YES 20a EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of many in Port Lor Port L of Item 18.) agent, prior PRIMARY CONTRIBUTING CAUSE OF DEATH 20f (City or town) 20c TIME OF NJURY Month, Day Year 20d INJURY OCCURRED 20e PLACE OF NJURY (Home, form, (County) (Stote) Hour o.m. Not While foctory, street, office oldg. etc.) of work ot work or its designated 21 I certify that I took charge of the remains described above, held on Autopsy Inspection [ Inquiry and in my apinion the funeral director. Notural couses X deoth resulted from Accident Suicide Hom cide Undetermined monner be retained CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE PUMENAL **EXAMINER'S** moy Heolth ( 23c NAME OF CEMETERY OR CREMATORY BURIAL, CREMATION 23d LOCATION (City or Town) (Stole) REMOVAL (Specify) Arlington National Com 256 REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR VR A15ME (5) 6M 1766



19-	Items 18-21 Film 393 MARYLAND STATE DEPARTMENT OF HEALTH 9-25-5/ ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
FOR STATE	#2554 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12663
ges 1.2 drown form PMN Pods of the Department of all Department of	1. PLACE OF DEATH 0 COUNTY ON Lagorner MARYLAND  b. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest form)  Takoma Park  d NAME OF HOSP TAL OR INSTITUT ON (If not in hospitol, give street address)  2 USUAL RESIDENCE (Where deceosed lived, it institut on Residence before admission) 0. STATE  MARYLAND  C CITY OR TOWN (If outside corporate limits, write RURAL and give neorest fown)  Takoma Park  0 STREET ADDRESS  E 15 RESIDENCE ON A FARM?
thours ofter death If Item 18 Give Pages 1 Office along with form	Washington San, 4 Hospital 1313 Jackson Ave. YES NOW  3 NAME OF DECEASED (1/ye or print) Paul Leslie Kelley Of DEATH 9 1967  5 SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED B DATE OF BIRTH 9 AGE (In years House House) Hours Min.  Male White Widowed Divorced 12-22-19 Hours Min.  100 SUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (Stote or foreign country) 12 CITIZEN OF WHAT
MEDICAL EXAMINER: This certificate should be executed within 24 hours ofter death. If a please execute the certificate, writing the word "pending" in pencil in Item 18 Give Pages 3, I director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form retained for your files.  **DIRECTOR: Page 3 should be used as a burial-transit permit. File pages lond 2 with the Nate Deat to burial, cremation, or removal, and in any event within 72 hours after death	13. FATHER'S NAME  Lestie Kelley  14. MOTHER'S NAME  Maryland  14. MOTHER'S NAME  Maryland  15. WAS DECEASED EVER IN U.S. ARMED FORCES  16. SOCIAL SECURITY NO  17. INFORMANT  (Yes, no, or unknown) (If yes give wor or dotes of service)  218-14-5110  Georgetta B. Kelley  7513-Jackson Aue.  18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c))  PART 1. DEATH WAS CAUSED BY:  18. MAREDIATE CAUSE (o) PROPERTY Barbiturate poisoning  ONSET AND DEATH  ONSET AND DEATH
This certificate shoul rificate, writing the war ld be forwarded to the used as a burial-or removal, and in any	Conditions, if only, which gove inse to immediate couse (o), storing the underlying couse (o)  Storing the underlying couse (c)  PART I OTHER SIGN FICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)  19 WAS AUTOPSY PERFORMED?  YES NO   200 EXTERNAL CAUSE WAS
DEPUTY MEDICAL EXAMINER: I sessory, pleose execute the certifical functal director. Page 4 should be may be retained far your files funeral DIRECTOR: Page 3 should eafth prior to burial, cremation, or respectively.	PRIMARY 20 or CONTRIBUTING TOOK overdose of sleeping pills  20c TIME OF INJURY Month, Day, Year 3:00 overdose of sleeping pills  20c TIME OF INJURY Month, Day, Year 3:00 overdose of sleeping pills  20c TIME OF INJURY Month, Day, Year 3:00 overdose of sleeping pills  20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED to the foctory, street, office bidg., etc) of the foctory, street, office bidg., etc) TakomaPark Montg. Md.  21. I certify that I took charge of the remains described above, held an Autapsy , Inspection , Inquiry , and in my apinion death resulted fram: Natural causes , Accident , Suicide , Hamicide , Undetermined manner .
TO DEPUTY MEDICA necessory, please exthe funeral director. 5 may be retained in the EUNERAL DIRECTORY Health prior to buring	ACTUAL SIGNATURE SIGNATURE EXAMINER'S NAME (Type) John G. Ball  22. DATE SIGNED  ASSISTANT MED CAL EXAMINER B. DEPUTY MEDICAL EXAMINER B. Address (Street, city, town, or county)  230 BURIAL, CREMATION, BREMOVAL(Specify)  Sept. 7, 1967 Baltimore National Cemetery Baltimore, Maryland
VR A15ME (3)	Varner E. Pumphrey, Inc. Silver Spring, Md. DATE SEP 8 1967 yourse



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12655 12664 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) b COUNTY Montgomery o. COUNTY Maryland within 72 hours ofter MARYLAND b. CITY OR TOWN (If autside corporate limits-CLENGTH OF STAY IN 16 ( CITY OR TOWN (If autside carporate limits, write RURAL and give negrest town) write RURAL and give hearest fawn Brooke Grove Foundation requires that the death certificate be executed within 24 hou d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? papers Olney YES NO NAME OF remave carban First Middle 4 DATE completely Year DECEASED (Type or print) September 19 67 DEATH and in apy Event 6 COLOR OR RACE MARRIED DATE OF BIRTH AGE (in years IF UNDER 1 YEAR IF JNDER 24 HRS **NEVER MARRIED** Jast, birthdoy) Months Haurs DIVORCED WIDOWED and 100 JSUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CIT, ZEN OF WHAT during most of working life even if retired) INDUSTRY COUNTRY 2 physician in Louse Wil 13-EATHER S NAME RAL DIRECTOR: After this certificate has been signed by the attending physi; page 3 shauld be detached for use as the burial-transit permit. Then pl be filed with the State Dept, af Health prior ta burial, cremation, ar remayal, attending phys WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, ha, or unknown) (If we give wor or dotes of service) 1B. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c)) INTERVAL BETWEE PART I, DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (a) TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires the Page 4 may be retained by the haspital ar attending physician. DUE TO Canditions, if any, which gave rise to immediate cause (a), DUE TO stating the underlying cause WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO 20g ACCIDENT WAS JNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part Is of tem IB.) OR CONTR.BUT.NG CAUSE OF DEATH TO FUNERAL DIRECTOR: After this certification and a should be deforted (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (City or town) (County) Haur a.m. factory, street, office bldg., etc.) Not While at wark at wark 21. I certify that (t)-(this hospital) attended the deceased from January saw the deceased alive an and that death accurred at 11/15. M, from causes and an the date stated above 22c-SIGNATURE M.D DIRECTOR PHYS 22c PHYS CIAN'S 23d APDRESS NAME (Type) director, should be 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 230. BUR AL, CREMATION, 23d LOCATION (City or Town) (County) 9-12-1967 Cedar Hill Crematory Suitland Maryland SEP 13 196 25b REG STRARS SIGNATURE 24 FUNERAL DIRECTOROBERT E. Wilhelm Funeral Home VR A15 (4) 25M 1/67 1967 4308 Suitland Rd Suitland Maryland



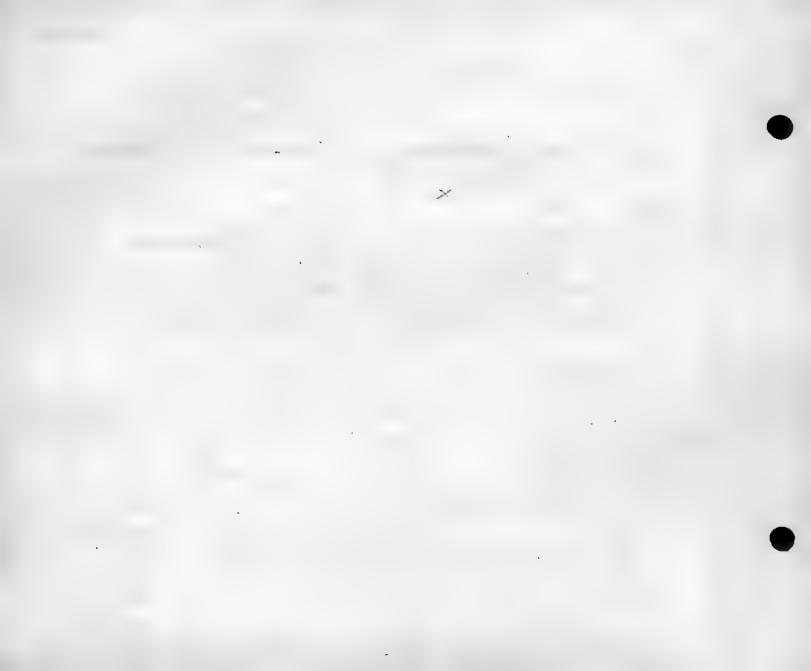
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12656 12665 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY CITY OR TOWN (If ourside corporate limits, write RURAL and give nearest town) MARYLAND c. LENGTH OF STAY IN 15 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 8 minths SIlver Whea Form d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Nucsing NO F 3. NAME OF DECEASED Y a DEATH (Type or pant) IF UNDER I YEAR SEX 7. MARRIED NEVER MARRIED Dovs WIDOWED 100 USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & State, or foreign country) 12 CIT ZEN OF WHAT during most of working file, even if retired) COUNTRY? misseuri 13. FATHER S NAME 14 MOTHER'S MAIDEN NAME ar remayal. Allie J. Stogner IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give wor or dotes of service 213-56-7481-T Mr. Cecil Kern 1901 Dayton St. 5 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).

PART I DEATH WAS CAUSED BY: burial-transit CEREBRAL VASCULAR ACCIDENT (THRONOGIS) IMMEDIATE CAUSE (o). INDEFINITE AKTERIO SCLEROSIS Conditions, if ony, which gove rise to immediate couse (a), **DUE TO** stating the underlying couse be aetached far use as the State Dept. af Health priar to PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) RIGHT 19 WAS AUTOPSY PERFORMED? STATUS (12/66) REDUCTION INTER-TROCHANTERIC FRACTURE YES 206. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18) 20o ACCIDENT WAS UNDERLYING [1] OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, form, 20f. (City or town) 20d INJURY OCCURRED (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year Hour o.m. foctory, street, office bldg., etc.) ne deceased from 2 /, 19 60 to 9/3, 1967, that (1) (we) last 19 67 and that death accurred at 7 35 M, from causes and an the date stated above. 21. I certify that (1) (this haspital) attended the deceased from\_ saw the deceased alive an\_\_\_\_\_ TO FUNERAL DIRECTOR: 22o. SIGNATURE 22b. DATE SIGNED MED.
DIRECTOR aurince 22d ADDRESS SPRING STREET, SILVER SPRING NO 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 230 BURIAL CREMATION. 23b. DATE THEREOF 3201 Bladensburg Rd. Sept. 5, 1967 It. Lincoln Crematory 250 RELD B 250 REC D BY REGISTRAR 24. FUNERAL DIRECTOR
Carter, TEATE SEP VR A15 (4) 25M 1/67 8 1967 8434 Georgia Ave S.S.



MAKTLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12666 CERTIFICATE OF DEATH by the funeral Pages 1 and 2 urres that the death certificate be executed within 24 hours after death I. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institut an Residence befare admission a. COUNTY **b.** COUNTY carbon papers. Pages 1 ent, within 72 hours after MARYLAND b CITY OR TOWN (If outside corporate limits. C LENGTH OF STAY IN 16 c CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) write RURAL and give nearest town) and completely filled in d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) B IS RESIDENCE ON A FARM? YES NO NAME OF Middle 4. DATE Last Dov Year DECEASED (Type or pnnt) OF DEATH 19 61 SEX 6 COLOR OR RACE AGE (In years 7. MARRIED NEVER MARRIED IF UNDER 24 HRS IF UNDER I YEAR remova lost birthdoy) Manths Doys Hours Male White

100. USUA. OCCUPATION (Give kind of work dane) WIDOWED DIVORCED KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fore an country) 12. CITIZEN OF WHAT during most of working the, even if retired) ease COUNTRY? gno 13. FATHER'S NAME be detached far use as the burial-transit permit. Then pl State Dept. af Health priar ta burial, crematian, or remaval, serman 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16 SOCIAL SECURITY NO (Yes, no, ar unknown) (If yes give war ar dates of service) by Jr Tacoma Pk. 1B. CAUSE OF DEATH (Enter only one couse per line for (p), (b), and (c) the INTERVAL BETWEEN PART I DEATH WAS CAUSED BY. ONSET AND DEATH IMMEDIATE CAUSE (o signed by DUE TO Canditians, if any, which gove rise ta immediate cause (a). DUE TO stating the underlying cause fo FUNERAL DIRECTOR: After this certificate has been lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1/01 WAS AUTOPSY PERFORMED? 20o, ACCIDENT WAS UNDERLYING [7] 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item/8.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c, TIME OF INJURY Month, Dov. Year 20d INJURY OCCURRED 20e. PLACE OF INJURY/(Home, farm, 20f. (City or town) (County) (State) While Not While Hour a.m. factory, street, office bldg., etc.) ATTENDING 21. I certify that (A) (this hospital) attended, the deceased from be retained director, page 3 shauld shauld be filed with the and that death occurred at 735 M, fram causes and on the date stated above. saw the deteased alive a 220. SIGNATURI 22b DATE SIGNED ATTENDING M.D. PHYS DIRECTOR PHYS. 22c PHYSICIAN'S 22d ADD9ESS NAME (Type) Page 4 BURIAL CREMATION 236 DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) 2 murs FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR ADDRESS VR A15 (4) Charles 20 M 1/66



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12858 12667 CERTIFICATE OF DEATH and 2 The law requires that the death certificate be executed within 24 haurs after death physician and campletely filled in by the funeral PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. COUNTY n. STATE Montgonery Maruland Montaomeru MARYLAND CITY OR TOWN (If autside carparate limits, C TENGTH OF STAY IN 16 c CITY OR TOWN (If autside carparate limits, write RURAL and give negrest town) write RURAL and give nearest town! year 5 Mo-Silver Spring Kensinaton d NAME OF HOSP TAL OR INSTITUTION (If not in haspital give street address) d STREET ADDRESS ON A FARM? ensinaton Gardens Nursing Home 8109 Genton Street NO RO NAME OF Middle DATE Last Manth First Day DECEASED OF September 24 19 67 EMMOL Kilgore (Type ar print) Ş. , SEX 6 COLOR OR RACE B DATE OF BIRTH IF UNDER 1 YEAR IF SINDER 24 HRS AGE (in years 7. MARRIED NEVER MARRIED gest birthday) White Decals. emale. WIDOWED DIVORCED 10a LSUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 12, CITIZEN OF WHAT 11 BIRTHPLACE (County & State, or foreign country) during most of working life even if retired) INDUSTRY COUNTRY? Pennsylvania Own Home 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Siders Marie the attending p 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address Md. būrial-trānsit permit. būrial, crematian, ar r (Yes, na, ar unknown) (If yes give war ar dates of service 215-50-1784 9. Kilgore-10101 Phoebe Lane Adelph CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c) INTERVAL BETWEEN signed by the burial-transit p PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 421 DUE TO CONGESTION Conditions, if any, which gave rise to immediate cause (a), DUE TO far use as the L FHealth priar tab stating the underlying cause has been PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? YES 🗌 NO 🔽 O FUNERAL DIRECTOR: After this certificate PHYSICIAN: 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of Item 18.) 20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home form. (City or town) (County) (State) Haur a.m. factory, street, affice bldg., etc.) Nat While at work be retained by 21. I certify that (I) (this haspital) attended the deceased fram and that death accurred at 12-25 M. fram causes and an the date stated above saw the deceased alive an 22b DATE SIGNED 22a. SIGNATURE K MD. DIRECTOR PHYS. 22c PHYSICIAN'S NAME (Type) ADDRESS director, 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23g. BURIAL CREMATION. 23b. DATE THEREOF (County) REMOVAL (Specify) Rolling Creek Cemetery Camp Hill. Pennsylvania VR A15 (4) 20 M 1/66



VR A15 (4) 25M 1/67

Goldberg Funeral Home

12659 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. COUNTY a. STATE b. COUNTY MARYLAND b CITY OR TOWN (f outside corporate limits, write RURAL and give nearest town) CLENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOM d. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital, give street address) IS RESIDENC ON A FARM? NO 🔀 NAME OF Year DECEASED OF DEATH Abraham (Type or print) Kreuter NMN 19 6 / AGE (In years last birthday) 6. COLOR OR RACE IF JADER 1 YEAR IF UNDER 24 HRS 7. MARRIED NEVER MARRIED CANC DIVORCED WIDOWED 1-11-01 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 1) BIRTHPLACE (County & State or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? MER 13. FATHER'S NAM MOTHER'S MAIDEN NAME IS. WAS DECEASED EVER IN J.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) **DUE TO** Conditions, if any, which gave rise to immediate cause (a), DUE TO stating the underlying cause WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 120b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part + or Rbrt II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Day, Year 20e. PLACE OF INJURY (Hame, form, 20d INJURY OCCURRED (City or town) (County) (State) Hour to m. Not While factory, street, affice bldg , etc.) at work L 21. I certify that (I) (this haspital) attended the deceased from saw the deceased alive on. 19 6, and that death occurred at D:05 M, from couses and on the date stated above. 22b. DATE SIGNED **ADDRÉSS** 22c. PHYSICIAN'S NAME (Type) Gilbert B. Cushner Ham 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23o. BUR AL, CREMATION, 23d LOCATION (City or Town) (County) (State) Burlal (Specify) Beth David Cemetery 9-29-1967 Elmont, L. I., New York 250 REC'D BY REG STRAR 24 FUNERAL DIRECTOR 1967

4217 9th Street N.W.

DAMPOT 2



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12669 12590 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEPT. O. COUNTY 2 USUAL RESIDENCE (Where geceosed lived if institution Residence before admiss on) o. STATE b. COUNTY MARYLAND delay h LENGTH OF STAY IN 16 limits, write RURAL and give nearest town) B IS RESIDENCE ON A FARM? State Dep d NAME OF HOSPITAL O INSTITUTION ( f not in hosp tal, give street address) farwarded to the Chief Medical Examiner's Office along with farm pencil in Item 18. Give Poges No 🔀 be executed within 24 hours ofter death 3 NAME OF DECEASED OF DEATH the the (Type or print) AGE (In years lostybirthdoy) IF UNDER I YEAR MARRIED IF LINDER 24 HRS NEVER MARRIED Months Hours WIDOWED DIVORCED in any event within 72 hours after death 06 KIND OF BUSINESS OR 12 CITIZEN OF WHAT 10a USUAL OCCUPATION (Give kind of work done BIRTHPLACE (State or foreign during most of working life, even if refired) **NDUSTRY** COUNTRY 2 3 FATHER'S NAME 14 MOTHER'S MAIDEN NAME bur al-transit permit. File IS WAS DECEASED EVER NUS ARMED FORCES? (Yes, no or unknown) (If yes give wor or dates of service) CAUSE OF DEATH (Enter only one duse per ne for (a), (b), ond (c))
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN Coronary Insufficiency Acute-ONSED AND DEATH IMMEDIATE CAUSE (a) writing the word This certificate should DUE TO Cardio Vascular Disease-Years Conditions, flony, which gove rise to immediate couse (o). DUE TO stating the underlying couse gud last 19 WAS AUTOPSY PERFORMED? ar remayal, PART II. OTHER S.GNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION GIVEN IN PART 1(o) CERT F CATION NO X the certificate, 20o EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port or Port I of tem 1B) 3 should 4 should t PRIMARY Or CONTRIBUTING CAUSE OF DEATH. ta burial, crematian, MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d, INJURY OCCURRED 20e PLACE OF .NJURY (Home, form 201 (City or Town) (Stote) (County) Hour o.m. foctory, street, office bldg, etc.) Not While FUNERAL DIRECTOR: Page ot work Inspection IX Inquiry 🔨 21 I certify that I took charge of the remains described above, held on Autopsy and in my apinion death resulted fram: Natural causes Accident | Suicide Hamic de Undetermined manner funeral directar be retained CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER priar SIGNATURE DEPUTY MEDICAL EXAMINER **EXAMINER'S** Health JOHN G. may BALL NAME (Type) Address (Street, city, town or county) ethesda. Md. 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 230 BUR AL, CREMATION, 23d LOCATION (City or Town) (County) 0 CHEYALETOn 9/5/67 Cedar Hill Crematory Prince Geo. Co. 1967 256 REGISTRARS S GNATURE ADDRESS RECD BY REGISTRAR 24. FUNERAL DIRECTOR udska VR A15ME (编 Robert A. Pumphrey Bethesda, Md. DATE 6M 1/67

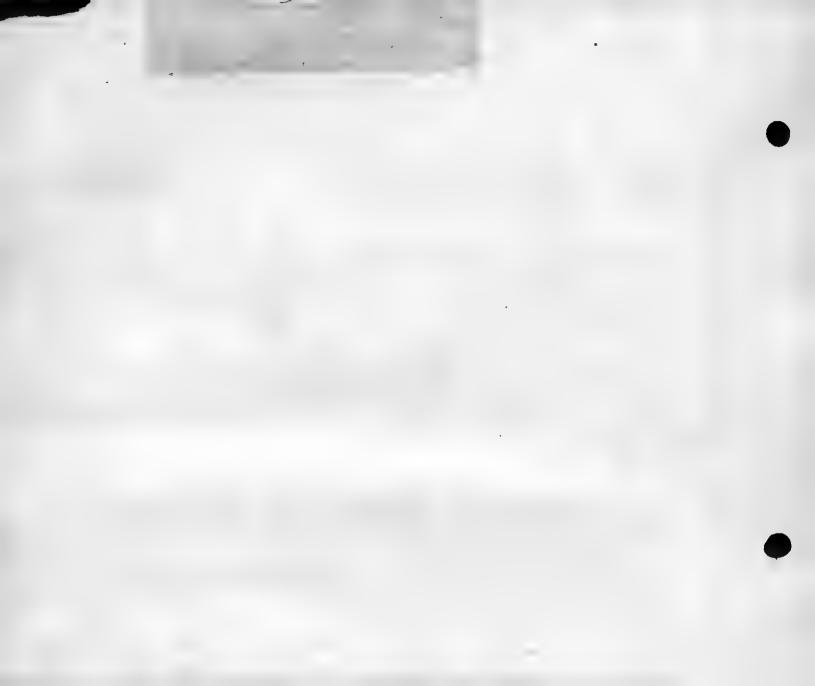


MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH death. PLACE OF OEATH 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) b. COUNTY. after Maryland b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARYLAND Montholic ry c. CITY DR TDWN (If outside corporate limits, write RURAL and give nearest town) C. LENGTH DF STAY IN 1b hours Kensington vears Kensing ton d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE DN A FARM? 3005 Edgewood Rd. 30 15 Eds ewood Rd. ND X executed within NAME DE Middle 4. DATE Day DECEASED OF DEATH event, S. (Type or print) George 19 67 6. COLOR OR RACE 9. AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS | last birthday) | Months | Days | Hours | Min. 8. DATE OF BIRTH 7. MARRIED NEVER MARRIED and in any Jan. 1904 Oriental WIDDWED e attending physician a ermit. Then please re m, or removal, and in a 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

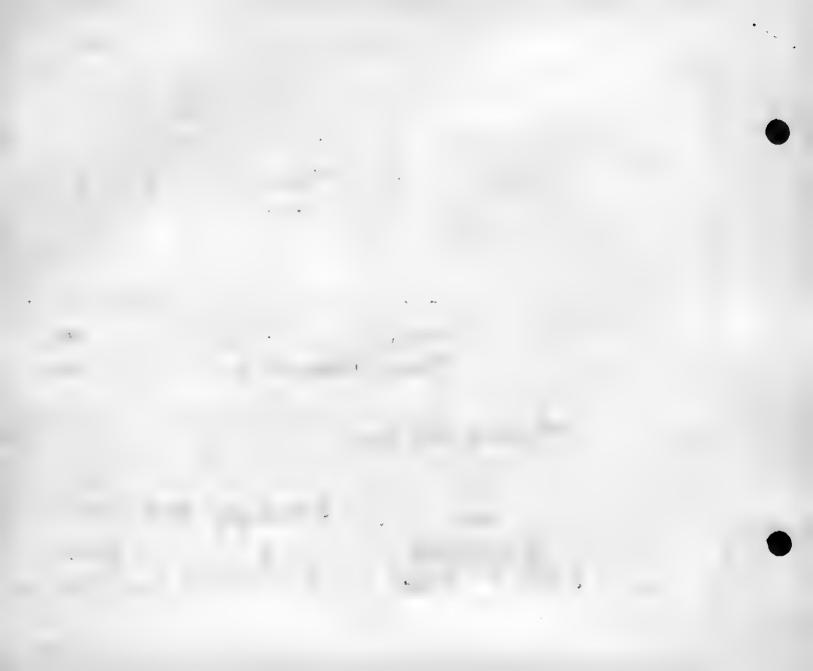
10b. KIND DF BUSINESS DR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN DF WHA OR ATTENDING PHYSICIAN: The law requires that the death certificate be be retained by the hospital or attending physician. **COUNTRY?** Tokyo. Japan Printer 13. FATHER'S NAME 14. MDTHER'S MAIDEN NAME Shobel Kushida Unknown 15. WAS DECEASED EVER IN U.S. ARMED FDRCES? (Yes, no, or unkown) (If yes give war or dates of service) 16. SDCIAL SECURITY ND. 17. INFORMANT Address TO FUNERAL DIRECTOR: After this certificate has been signed by the atten director, page 3 should be detached for use as the burial-transit permit. should be filed with the State Dept. of Health prior to burial, cremation, or in the state Dept. Same as Itom 2. Hazel Kushida 18. CAUSE OF OEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe Malnutrition DUE TO Carcinomatosis (Primary \*Lower Esophagus Conditions, If any, which (b) gave rise to immediate DUE TD cause (a), stating the underlying cause last. CERTIFICATION PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTDPSY PERFORMED? YES [ ND IT 20a. ACCIDENT WAS UNDERLYING TO DR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HDW INJURY DCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) MEDICAL 20d. INJURY DCCURRED 20e. PLACE DF INJURY (Home, farm, factory, street, office bldg., etc.) 20c. TIME DF INJURY Month, Day, Year 20f. (City or town) (County) (State) Hour a.m. While Not While at work at work 21. I certify that (!) (this/hospital) attended the deceased from August 19 67 to Sent 13 . 19.67 . that (I) (we) last and that death occurred at M. from the causes and on the date stated above. saw the deceased alive on SCDt 22a. SIGNATURE 22b. DATE SIGNED STAFF PHYS. Sept 13, 1967 DIRECTOR TO HOSPITAL ( Page 4 may | PHYSICIAN'S 11.666 Old Gerretown Road Thibadeau Robert Larvinad 20052 BUR, AL, CREMATION, 1 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY 23d, LOCATION (City, town or county) REMOVAL (Specify) Parklawn Cemetery Rockville, maryland 9-16-67 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE ADDRESS 24. FUNERAL DIRECTOR PUMPHRFY, Bethesda, Maryland VR A15 (4) 15M 4-64



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 62 12671 CERTIFICATE OF DEATH death. remuires that the deoth certificate be executed within 24 haurs after Meoth puo the funeral 1. PLACE OF GEATH 2. USUAL RESIDENCE (Where deceased lived, if institution Residence betare admission) a. COUNTY . b. COUNTY haurs ofter lontgomery MARYLAND b CITY OR TOWN (If outside corporate limits. c LENGTH OF STAY IN 16 c CITY OR TOWN (If autside carparate limits, write RURAs and give nearest tawn) write RURAL and give nearest jawn) month Son popers. Within 72 ha filled in I d. NAME OF HOSP TAL OR INSTITUTION (If not in hospital, give street oddress) d STREET ADDRESS IS RESIDENCE ON A FARM Nichols esmor arium NO 🔽 3 NAME OF Middle DATE CONTROL I Year DECEASED OF Kushner 196 (Type or pant) n'x event, ÖEATH AGE (In years last birthday) IF UNDER 24 HRS 6. COLOR OR RACE 1 YEAR 7. MARRIED CO NEVER MARRIEO ond comp Months WIDOWED DIVORCEO 10a JSUAL OCCUPAT ON (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? physicion o INDUSTRY Store Owner 13 FATHER S NAME MOTHER'S MAIDEN NAME bur of transit permit. Them pl burial, cremation, or removal, the attending phy: INBINDER hecca UShhal Bethesda Md. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT (Yes, no, prunknown) (If yes give war or dates of service 6300 CARNEGIE Joyce K. TROSHINSKY 1B. CAUSE OF DEATH (Enter only one couse per line for (a), (b), ogd (c) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (a) signed by **OUE TO** leen Sacrun Conditions, if any, which gove rise ta immediate cause (a), **OUE TO** stating the underlying cause as the prar to has been PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19 WAS AUTOPSY PERFORMED? USe Heolth ( NO F this certificate 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20g ACCIDENT WAS UNDERLYING by the hospital OR CONTRIBUTING CAUSE OF DEATH J-0 detached (IF EITHER, NOTIFY MEDICAL EXAMINER Stote Dept 20c. TIME OF INJURY Manth, Day, Year 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, fgrm, (City or town) (County) (State) Hour a.m. Not While factory, street, office bldg., etc.) at wark FUNERAL DIRECTOR: After 21. I certify that (I) (this haspital) attended the deceased fram. should be retained and that death occurred at from duses and an the date stated above. saw the deceased alive an 22a SIGNATHIN director, page 3 M.D DIRECTOR PHYS 22c. PHYSICIAN'S 22d. ADDRESS Poge 4 may NAME (Type) 23a. BURIAL, CREMATION, 23b. DATE THEREO! 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) a (State) REMOVAL (Specify) 9 24 FUNERAL DIRECTOR 2Sb. REGISTRAR S SIGNATURE VR A15 (4) 25M 1/67

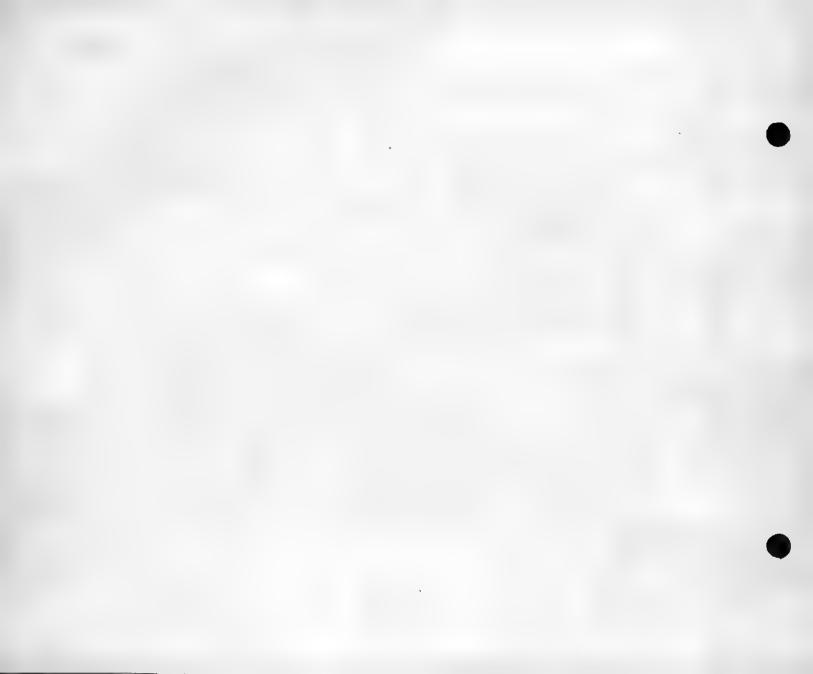


MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12863 CERTIFICATE OF DEATH 12672 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) PLACE OF DEATH Montgomery p. COUNTY o. STATE Maryland b COUNTY Montgomery MARYLAND 24 hours after b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 16 c CITY OR TOWN (If gutside corporate limits, write RURAL and give negrest town) write RURAL and give nearest town) ician and completely filled in by the lease remayescarbon papers. Pagand in any event within 72 hours Years Clan Dobo d. NAME OF HOSP TAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS IS RESIDENCE ON A FARM? 1- Tuttonwood Lane Inttonwood Lane YES NO □ NO O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within NAME OF Middle 4 DATE Doy Year DECEASED 2 DATE OF BIRTH (Type or pant) DEATH 19 6 7 IE LINDER 1 YEAR 5 SEX 6 COLOR OR RACE IF UNDER 24 HRS 7 MARRIED **NEVER MARRIED** 9 AGE (In years (de pirthdox) Months Doys Hours White Sc. t.25, 1873 'amila WIDOWED 1 DIVORCED physician and chen please rema 10b KIND OF BUSINESS OR 10o USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired)
Artist INDUSTRY COUNTRY? Mexico Mexi co 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ar remayal. Francisco Raymundo Augustina Aquilar 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Son Same (Yes, no, or unknown) (If yes give wor or dates of service as Item 2. 559-70-7883[I] Milic Kybal crematian, 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c), PART I DEATH WAS CAUSED BY signed by the a burial-transit pe INTERVAL BETWEEN CONSET AND DEATH IMMEDIATE CAUSE (o) Page 4 may be retained by the haspital or attending physician. DUE TO Pycloneyhritis Conditions, if ony, which gave nse to immediate cause (a), DUE TO stating the underlying couse lost. 19 WAS ALTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) NO T After this certificate 20o. ACCIDENT WAS UNDERLYING [ 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Part II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d. INJURY OCCURRED (City or town) 20c. TIME OF INJURY Month, Day, Year 20e PLACE OF INJURY (Home, form, (County) (Stote) Hour o.m. foctory, street, office bldg., etc.) Not While at work of work 21. I certify that (I) (this haspital) attended the deceased fram. deceased fram Scytembol 955 to 1967, and that death accurred at 450 M. 1967, that (I) (we) last saw the deceased alive on. AM, fram couses and an the date stated above FUNERAL DIRECTOR: 22o. SIGNATURE 22b DATE SIGNED STAFF MED DIRECTOR director, page 3 should be filed w MD 22d ADDRESS 22c PHYSICIAN'S NAME (Type) C 2>3 23b DATE THEREOF 23d LOCATION (City or Town) 230 BURIAL CREMATION. 23c NAME OF CEMETERY OR CREMATORY (County) (Stote) PREMOVAL (Specify) 9-29-67 Gate of Heaven Cem. Silver Spring, Laryland 0 24. FUNERAL DIRECTOR ADDRESS 250 REC'D BY REGISTRAR 2Sb REGISTRAR S SIGNATURE VR A15 (4) Milanen Bethesda, Maryland 1967 DAGCT 2 25M 1/67



12664 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12673 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death. the funeral PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) n. COUNTY o. STATE b COUNTY New York Montgomerv MARYLAND signed by the attending physician and completely filled in by the f burial-transit permit. Then please remave carban pepels. Pages burial, crematian, or removal, and in any event, within 12 bours afte b CITY OR TOWN (If outside corporate mits, write RURAL and give nearest town) C LENGTH OF STAY IN 1b c CITY OR TDWN (If autside corporate limits, write RURAL and give nearest town) 136 days New York Bethesda d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) IS RESIDENCE DN A FARM? d. STREET ADDRESS The Clinical Center, Bethesda, Maryland 14 Monroe Street NO IX YES NAME OF Middle Ind DATE Month First Day Yea DECEASED (Type or print) Argie (NMN) Lagouras DEATH September 19 67 SEX 9. AGE (In years IF UNDER 1 YEAR | IF UNDER 24 HRS 6. COLDR OR RACE 8 DATE DE BIRTH 7. MARRIED NEVER MARRIED X lost birthdoy) Months | Dovs White WIDOWED [ DIVORCED 29 August 1939 Female 1Db KIND OF BUSINESS OR 1Do USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 12. CIT ZEN OF WHAT 11 BIRTHPLACE (County & Stote, or foreign country) INDUSTRY COUNTRY? Banking Secretary Greece USA 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME Patra Chakides Michael Lagouras 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT The Medical Recordess 16. SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give war or dates of service) 059-32-0511 The Clinical Center, Bethesda, Maryland No 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c))
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH CAUSED BY: Bilateral bronchopneumonia, terminal aspiration Conditions, if ony, which gave (b) Malignant carcinoid syndrome with extensive 18 months rise to immediate couse (a). metastatic involvement DUE TO stating the underlying couse as the prior tal 19 WAS AUTDPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) YES 🔀 NO [ **MIRECTOR:** After this certificate 20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Part II of item 18) (IF EITHER, NOTIFY MEDICAL EXAMINER 2Dd IN, JRY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (State) 2D: TIME OF INJURY Month, Doy, Year factory, street, office blag, etc.) Not While TO HOSPITAL OR ATTENDING of work 21. I certify that (1) (this haspital) attended the deceased from May 8, 1967, to September 1967, that (4) (we) last saw the deceased alive an September 21967, and that death accurred at 10:10th, from causes and an the date stated above. be retained 220 SIGNATURE 22b. DATE SIGNED ATTENDING STAFF X 22 Sept. 1967 director, page 3 shauld be filed v M.D. PHYS DIRECTOR Clinical Center, National TO FUNERAL NAME (Type) Robert I. Keimowitz, MD Institutes of Health, Bethesda, Md. 23c. NAME OF CEMETERY OR CREMATORY 23b DATE THEREOF 23d. LOCATION (City or Town) (County) (Stote) 230 BURIAL, CREMACION 250. RECD BY REGISTRAR 1400 Ch VR A15 (4)

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12665 12674 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death . PLACE OF DEATH and campletely filled in by the funeral remove carbon papers. Pages I and 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. COUNTY a. STATE MARYLAND Nontgamery TOWN (If outside carparate hours c LENGTH OF STAY IN 15 c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) papers. Pages write RURAL and give negrest town d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) e IS RESIDENCE ON A FARM? d STREET ADDRESS YES NO g physician and curing then please remave carbon please remave carbon please remave remains and premise the property of the premise of the pr NAME OF Doy Yea! DECEASED OF DEATH 20 (Type or print) 19 SEX IF UNDER F UNDER 24 HRS 6 COLOR OR RACE 7. MARRIED NEVER MARRIED DATE OF BIRTH 9. AGE (In years last birthday) Months Doys -2-88 Hours 6 WIDOWED DIVORCED 10a USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR 12 CIT ZEN OF WHAT 11. BIRTHPLACE (Caunty & State, or foreign country) during mast of warking life, even if retired) **INDUSTRY** 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME burial, cremation, ar remayal, Winters 17 INFORMANT (Yes, na, or unknown) Iff yes give war ar dates of service 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c), PART I DEATH WAS CAUSED BY INTERVAL BETWEEN ONSET AND DEATH signed by the burial-transit IMMEDIATE CAUSE (a) **10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires the Page 4 may be retained by the haspital ar attending physician. DUE TO 12 hours. Conditions, if any, which gave nse ta immediate cause (a), DUE TO stating the underlying couse After this certificate has been be detached for use as the State Dept. of Health prior to WAS AUTOPS) PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO) RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) M' Leture NO 20b, DESCRIBE HOW INJURY OCCURRED (Enter nature at injury in Port 1 at Part II at item 18.) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, farm (C ty or town) (County) (Stote) factory, street, affice bldg., etc.) Hour a.m. Not While at wark 2! I certify that (1) (this haspital) attended the deceased fram director, page 3 should should be filed with the TO FUNERAL DIMECTOR: saw the deceased alive an and that death accurred at 10:10 A.M. from causes and an the date stated above 22o. SIGNATURE DATE SIGNED DIRECTOR M.D. 22d. ADDRESS 22c. PHYSICIÁN S NAME (Type) 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) BURIAL, CREMATION REMOVAL (Specify) Ridge Cemeterv Bikesville. Md. 250. RECD BY REGISTRAR 25b REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 25M 1/ 1967



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12675 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) PLACE OF DEATH gud o. COUNTY o. STATE b. COUNTY NONTGOME RY Maryland MARYLAND Montgomery CITY OR TOWN (If autside corporate limits, c. LENGTH OF STAY IN 15 c CITY OR JOWN (If autside corparate limits, write RURAL and give nearest tawn) write RURAL and give nearest town)
Silver Spring ve carban papers. Paç event, within 72 haurs Rockville completely filled in d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STRFET ADDRESS e IS RESIDENCE ON A FARM? 4501 Grenoble Court YES NO IX NAME OF Middle DATE Day Year DECEASED (Type or pnnt) DEATH SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED DATE OF BIRTH AGE Mi years F UNDER 1 YEAR IF JNDER 24 HRS last birthday) Months Days Haurs in any ( WIDOWED DIVORCED puo 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT 11, BIRTHPLACE (County & State, or fareign country) during Post of working life, even if COUNTRY? INDUSTRY AROLIK 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Winifred R. Lancaster Lottie Hudgins 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address (Nest, no, ar unknown) (If yeq give was ar dates at service) Anita L. Lancaster- wife - same itom 3 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) INTERVAL BETWEEN PART I DEATH WAS CAUSED BY. ONSET AND DEATH IMMEDIATE CAUSE (a) DUE TO Canditions, if any, which gave rise to immediate cause (a), DUE TO stating the underlying couse WAS AUTOPSY PERFORMED? has PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(0) YES NO 20o. ACC DENT WAS UNDERLYING [ 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or town) (County) (Stote) Hour a.m. factory, street, affice bldg., etc.) Nat While 21. I certify that (1) (this hospital) attended the deceosed from Acad-23 1. to Sent 24 . 196 19.24 that (1) (we) last be retained TO FUNERAL DIRECTOR: 22a. SIGNATURE 22b DATE SIGNED ATTENDING STAFF PHYS. M D page 3 PHYS 22d. ADDRESS 22c PHYSICIAN'S NAME (Type) 120 SILVER SPRINGS YU director, d NION (City or Town) 23a. BUR AL, CREMAT ON 23c NAME OF CEMETERY OR CREMATORY (County) (Stote) Md. BREMOYAL (Specify) Montg. Parklawn 256 REGISTRAR 5 SIGNATURE uneral Home Rockville Pike VR ⊞15 (4) 25M 1/67 1967



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O HOSPITAL Page 4 may O FUNERAL director, pa	23	BURIAL, CREMATION,	236 DATE THEREO	F 23	C NAME OF CEMETER			3d LOCATION (Cit	y or Tawn)	(County)	(Stote)	
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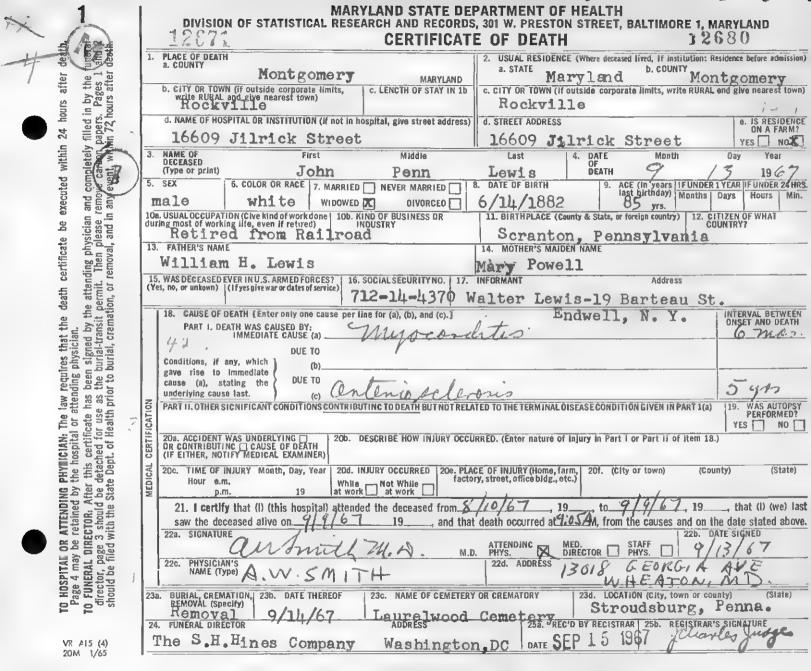
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W, PRESTON STREET, BALTIMORE, MARYLAND 21201 12677 MEDICAL EXAMINER'S CERTIFICATE OF DEATH HEALT HIDEPT. 2 USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) PLACE OF DEATH a STATE o, COUNTY nontamer C LENGTH OF STAY IN 15 OR TOWN'(If outside corporate imits, write RURAL and eve negrest town) Jutside corporate I'm gnd d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give 'pending" in pencil in Item 18. Give Pages 1, et Med cal Examiner's Office along with farm NO DY be executed within 24 hours after death NAME OF DECEASED OF DEATH (Type or print) last-birthday) Months Days DIVORCED 10a USUAL OCCUPATION (Give kind of work done IOH KIND OF BUSINESS OR 12 CITIZEN OF WHAT during most of warking life even if retired) INDUSTRY and in any event within 72 haurs aft 13. FATHER S NAME 15. WAS DECASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes give wor or dates of service) 16. SOCIAL SECURITY NO. 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) ) PART I DEATH WAS CAUSED BY: ONSET AND BEATH IMMEDIATE CAUSE (a) writing the ward DUE TO Conditions, if any, which gave rise to immediate cause (o), DUE TO stating the underlying cause 19 WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINA, D.SEASE CONDITION G.YEN N PART (0) NO IX 20a EXTERNAL CAUSE WAS PRIMARY ♥ ar CONTRIBUT NG ☐ CAUSE OF DEATH 20b DESCRIBE HOW INJURY OCCURRED [Enter nature of in Lty in Part I or Part II of item 18] neak in Power window of station Wagon 20c T.ME OF NJURY Month, Day, Year 20e PLACE OF INJURY (Hame, farm, ((ity ar tawn) (State) Nat While at wark may be retained for your FUNERAL DIRECTOR: Page 21 I certify that I took charge of the remains described above, held on Autopsy , Inspection X. Inquiry X. ond in My opinion death resulted from Notural couses , Accident , Suicide , Hamicide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MED CAL EXAM NER SIGNATURE DEPUTY MEDICAL EXAMINER A **EXAMINER'S** JC'N G. BALL Address (Street, city, town, or county) Bethesda. in. NAME (Type) 23d LOCAT ON (City or Town) 23a BURIAL CREMATION. 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY (County) REMOVAL (Specify) 9-27-67 Gate of Heaven Cem. Silver Spring, Maryland Burial 2So REC'D BY REG STRAR 24 FUNERA, DIRECTOR ADDRESS 25b REGISTRAR S SIGNATURE VR A15ME PUMPHRCY, Bethesda, Maryland 6M 1/67





MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12679 CERTIFICATE OF DEATH 12679 The law requires that the death certificate be executed within 24 hours after death. pletely filled in by the funeral carban papers. Pages I apdrent, within 72 haurs after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. COUNTY MONT GOMERY o. COUNTY o. STATE MONTGOMERY MARYLAND b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) SANDY SPRING 1 HOUR d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS IS RESIDENCE ON A FARM? 18600 BROOKE ROAD MONTGOMERY GENERAL HOSPITAL YES X NO NAME OF First Middle 4. DATE Lost Month Day Year campletely DECEASED HAROLD DISNEY 27 (Type or print) LETHBRIDGE DEATH 19 67 AGE (In years jost birthday) In dray the SEX IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8 DATE OF BIRTH Months Hours MALE 6-21-12 WHITE WIDOWED DIVORCED ond 10o USBAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT COUNTRY? USA INDUSTRY Farm attending physician termit. Then please MARY LAND FARMER 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME burial, cremation, or removal, JOHN LETHBRIDGE ANNIE DISNEY 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. Address (Yes, no, or unknown) (If yes give war or dates of service) MEDICAL RECORD DEPT. No IB. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY. signed by the c burial-transit p IMMEDIATE CAUSE (o) Page 4 may be retained by the haspital ar attending physician. DUE TO Conditions, if ony, which gove rise to immediate cause (a), DUE TO stating the underlying cause ve aetached for use as the State Dept. af Health priar ta has been lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? CERTIFICATION YES 📉 NO OR ATTENDING PHYSICIAN: 20o ACC DENT WAS UNDERLYING [ 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Not While Hour om foctory, street, office bldg., etc.) of work O FUNERAL DIRECTOR: After 21. I certify that (1) (this haspital) attended the deceased from director, page 3 shauld shauld be filed with the and that death occurred at 9:30AM, from couses and on the date stated above saw the deceased alive an 22a SIGNATURE 22b. DATE SIGNED **ATTENDING** 9-27-67 M.D PHYS DIRECTOR 22d. ADDRESS 22c PHYSICIAN'S NAME (Type) MEDICAL CENTER, SANDY SPRING. MD. C. H. LIGON, M. 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23o BURIAL, CREMATION 23d LOCATION (City or Town) (County) (State) Bur tonsville. Maryland Sept. 30.1967 Burtonsville 24. FUNERAL DIRECTOR 2So REC D BY REGISTRAR 2Sb REGISTRAR'S SIGNATURE VR A15 (4) 25M 1/67 Barber Lay tonsville, Md. DATE SEP 29 196/ "Charles







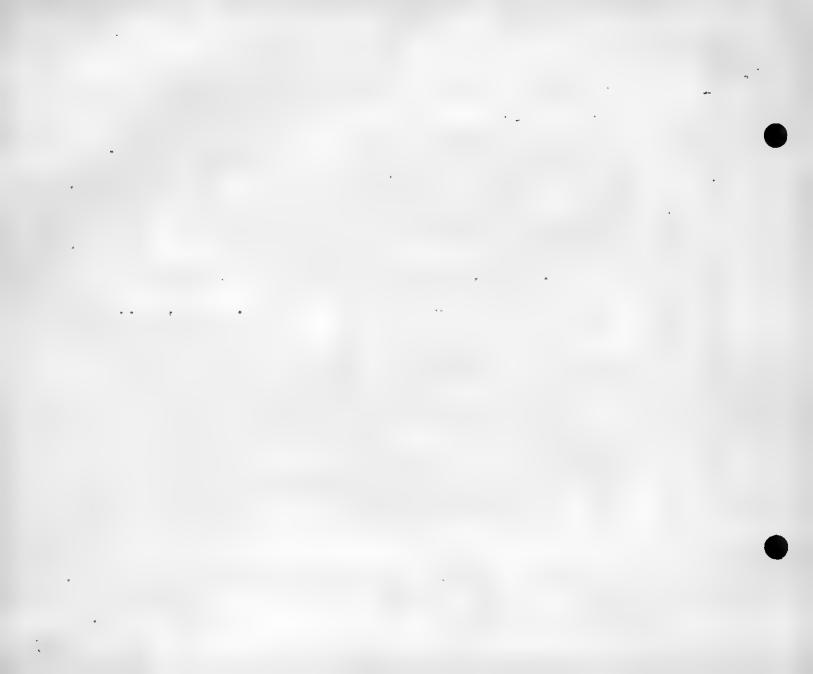
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 12681 MEDICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH BEPT. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. COUNTY b. COUNTY a. STATE Montgomery Marvland Montgomery MARYLAND any delay Thecessary, 2, and 3 to the funeral PM3. Page 5 may be ath. CITY OR TOWN (if outside corporate limits, write RURAL end give nearest town) c. CITY OR TOWN (If outside corporete limits, write RURAL end give neerest town) c. LENGTH OF STAY IN 1b Bethesda Bethesda e. IS RESIDENCE d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS ON A FARM? 8315 Brook Lane, 8315 Brook Lane, Apt. NO X Stat 3. NAME OF DATE Month Middle Last DECEASED DEATH Martha Portwood Lewis (Type or print) September 19 2 with within s after death. If a 8. Give Pages 1, 2 long with form P OATE OF BIRTH AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS 5. SEX 6. COLOR OR RACE 9. 7. MARRIED TO NEVER MARRIED last birthday) Months Hours Female White WI00WE0 OIVORCEO X July 21. 67 1900 YES. l and a along with 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) IOD. KING OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY? 11. BIRTHPLACE (Stete or foreign country) Federal Government Kentucky USA iges 1 13. FATHER'S NAME 14. MOTHER'S MAIOEN NAME 24 hours Item 1 E.E William A. Powell Ida Nave File 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16. SOCIAL SECURITY NO. Address 17. INFORMANT Examiner's Of (Yes, no. or unknyn) (If yes give war or dates of service) permit. I removal, Item 2. EXAMINER: This certificate should be executed within certificate, writing the word "pending" in pencil is ould be forwarded to the Chief Medical Examiner's 215-46-4935 Judd Same as No Norma INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). ONSET AND DEATH PART I, DEATH WAS CAUSED BY: burial-transit 9 IMMEDIATE CAUSE (a cremation, DUE TO Conditions, If any, which (d) gave rise to immediate DUE TO cause (a), stating the œ underlying cause last. ed as burial WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO OFATH BUT NOT TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION YES X NO Sign DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 1) of Item 18.) o e 20a. EXTERNAL CAUSE WAS PRIMARY Or CONTRIBUTING 3 should lagent, pri CAUSE OF DEATH. MEDICAL 20f. (City or town) (County) (State) the certificate, should be forward 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, form, 20c. TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) Hour a.m. Not While et work \_\_\_ at work 19 designated 21. I certify that I took charge of the remains described above, held an Autopsy inquiry and in my opinion Inspection es S Suicide Homicide Undetermined manner Natural causes 1 Accident death resulted from DIRECTO CHIEF MEDICAL EXAMINER your Page SIGNATURE 01 for DEPUTY MEDICAL EXAMINER FUNERAL I Address (Street, City, Town, or county) director. retained OF CEMETERY OR CREMATORY LOCATION (City, town or county) BURIAL, CREMATION, OATE 23b. REMQVAL\_(Specify) 0 Maple Crove Cem. 9e22-57 Nicholasville. Kentucky Burial 25a, REC'O BY REGISTRAR | 25b, REGISTRAR'S FUNERAL OIRECTOR PUMPHR BY. Bethesda, Jaryland VR A15ME 3500 4-64



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12682 12573 CERTIFICATE OF DEATH ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY a. STATE b. COUNTY Montgomery MARYLAND Maryland b CITY OR TOWN (If autside carparate limits, c LENGTH OF STAY IN 1b c CITY OR TOWN (If gutside carparate limits, write RURAL and give negrest town) write RURAL and give nearest town) Bethesda 1 day (rura) Valley Lee completely filled in papers. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? YES NO Naval Hospital Drayden Road NAME OF Middle remave carban East 4. DATE Month Dov Year and in any event, wi DECEASED September 1967 Lewis 16 Roger Walter DEATH S SEX AGE (In years IF UNDER I YEAR 6. COLOR OR RACE NEVER MARRIED [29] 8. DATE OF BIRTH IF UNDER 24 HRS Hours Male Sept. 15, 1967 Cauc WIDOWED DIVORCED 1Do USUAL OCCUPATION (Give kind of work dane during most of yorking life, even if retired) 12 CITIZEN OF WHAT ID6 KIND OF BUSINESS OR 1) BIRTHPLACE (County & State, or foreign country) attending physician ( permit. Then please INDUSTRY COUNTRY? Patuxent River, Md. USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME burial, crematian, or remaval, Roger M. Lewis Linda Y. Foard WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17 INFORMANT Address (Yas, no. or unknown) (If yes give war or dotes of service) N/A Roger M. Lewis, Drayden Rd., Valley Lee, Md 18. CAUSE OF DEATH (Enter only one cause per line INTERVAL BETWEEN DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE for DUE TO Conditions, if any, which gave rise to immediate cause (a), DUE TO stating the underlying couse 19 WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g) YES A NO F 20g ACCIDENT WAS UNDERLYING ... 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 2Dd INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or fown) 20c TiME OF INJURY Month, Day, Year (County) (Stote) Haur a.m. foctory, street, office bldg., etc.) of work O FUNERAL DIRECTOR: After 21. I certify that (1) (this hospital) attended the deceased from Sept. 15, 1967, to Sept. 16, 1967, that (8) (we) last O HOSPITAL OR ATTEND Page 4 may be retained be filed with the saw the deceased alive an Sept. 16. 19.67, and that death occurred at a coopy, fram causes and on the date stated above. 22a SIGNATURE 226 DATE SIGNED STAFF PHYS Sept. 18.1967 M.D. Naval Hospital, Bethesda, Md. NAME (Type) director, should be BURIAL, CREMATION, REMOVAL (Specify) Burial 23c NAME OF CEMETERY OR CREMATORY 23d toCATION (City or Town) (County)

Baltimore, Maryland 23b. DATE THEREOF (State) Baltimore National 24 FUNERAL DIRECTOR 25g, REC D BY REGISTRAR 2Sb. REGISTRAR 5 SIGNATURE Lassahn Funeral Home ADDRESS VR A15 (4) 25M 1/67 7401 Belair Road, Baltimore, Maryland





## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12684 CERTIFICATE OF DEATH o. STATE b. COUNTY MARYLAND C LENGTH OF STAY IN 16 Washington D. C. d STREET ADDRESS 3801 Conn. Ave. N.W. 4 DATE Middle Last Sept. David Liepman DEATH

PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, finistitution Residence before admission). n. COUNTY Montgomery
b CITY OR TOWN (If auts de carporate limits,
write RURAL and give neorest tawn) c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) Rockville d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) IS RESIDENC ON A FARMS Potomac Valley Nursing Home YES 1 NO 1 3 NAME OF Day Year DECEASED (Type or print) S SEX JE UNDER 1 YEAR IF UNDER 24 HRS 6 COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH AGE ( n years (ash birthday) Hours White Aug. 11, 1906 Mala WIDOWED DIVORCED 100 JSUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **10b KIND OF BUSINESS OR** 11. BIRTHPLACE (County & State, or fareign country) 12 CITIZEN OF WHAT INDUSTRY S. New York 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Jules Liepman Hattye Wineberg IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT 16 SOCIAL SECURITY NO Rockville, Md. (Yes, na, at unknown) (If yes give wor at dates of service) 652-12-4573 Potomac Valley Rest Home' 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY INTERVAL BETWEEN ONSET AND DEATH Carcinomakosis IMMEDIATE CAUSE (a) DUE TO Canditians, if any, which gave rise ta immediate couse (a). DUE TO stating the underlying cause 19 WAS ALTOPS' PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE JERMINAL DISEASE CONDITION GIVEN IN PART 1(g) exizease. 200 ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or fown) (County) (State)

Haur o.m. factory, street, office blda., etc.) 21. I certify that (1) (this haspital) attended the deceased from account of the deceased alive an account of the date stated above 22a SIGNATURE 22b DATE SIGNED

NAMENTYLENJerome 23c NAME OF CEMETERY OR CREMATORY REMOVAL (Specify) Sept. 29.1967 Kensico Cem. Rockville FUNERA DIRECTOR ler Funeral Home

Rockville, Md.

23d LOCATION (City or Town) (County) Hawtl orne 25b REGISTRAR S SIGNATURE 25a REC'D BY REGISTRAR

(State) N . Y .

DIRECTOR

ADDRESS Ordway St. ' Wash. D.C.

O HOSPITAL OR ATTENDING PHYSICIAN: The low requires the Page 4 may be retained by the haspital or attending physician. TO FUNITRAL MIRECTOR: VR A15 (4) 25M 1/67

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death

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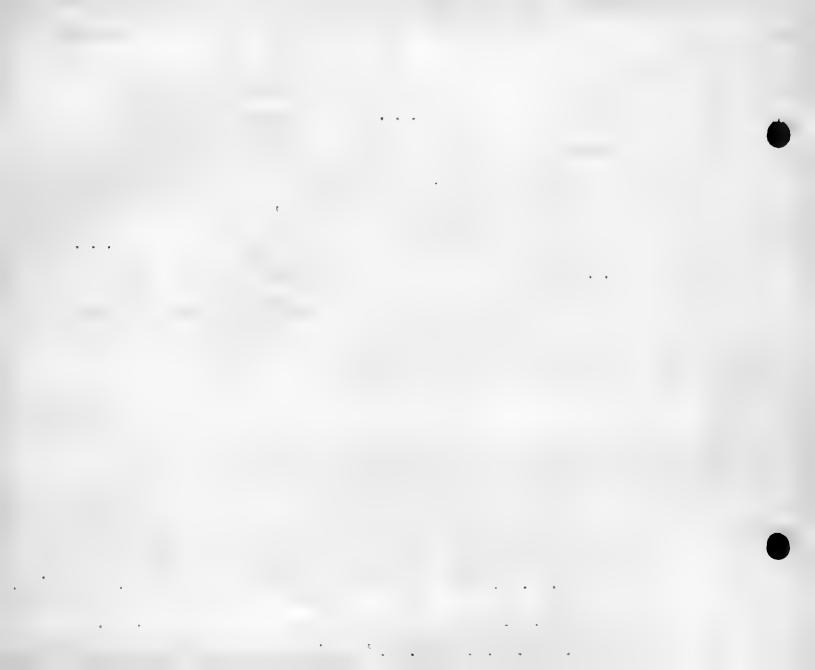
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this certificate

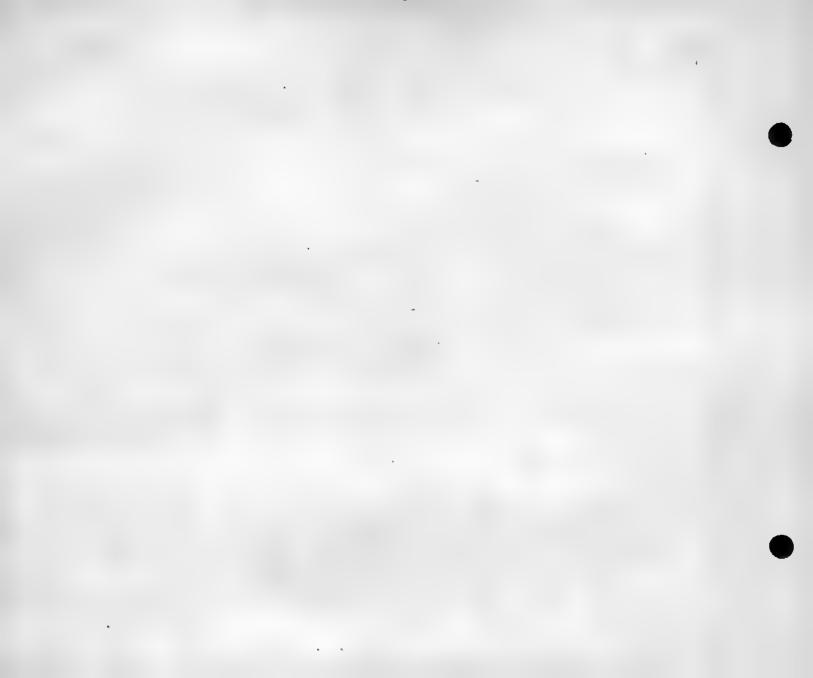
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12685 12676 CERTIFICATE OF DEATH PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death d to 1. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a COUNTY **a** STATE MONTGOMERY MARYLAND MARYLAND b CITY OR TOWN (If outside carporate limits, write RURAL and one necrest town) c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside carparote limits, write RURAL and ave nearest town) D.O.A. BETHESDA d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital give street address) d. STREET ADDRESS 8 IS RESIDENCE ON A FARM? 8603 BRADMOOR DRIVE SUBURBAN within YES NO X NAME OF First Middle Last 4. DATE Month completely DECEASED EDWARD OWEN SEPT 17 1967 LIKENS (Type or print) DEATH SEPT 3, S. SEX IF UNDER 24 HRS 7. MARRIED NEVER MARRIED 9. AGE (In years IF JNDER 1 YEAR 1901 lost birthday) WIDOWED DIVORCED 10o, USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR 12 CITIZEN OF WHAT 11 BIRTHPLACE (County & State, or foreign country) during most of working life even if retired)
SELF EMPLOYED U.S.A. KENTUCKY 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME buriol, cremation, or removal, MEDICAL, G.B. LIKENS RUTH COMBS 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17 INFORMANT Address (Yes, no, or unknown) (If yes give wor or dotes of service MAE MOUNT LIKENS WIFE SAME 18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c)) INTERVAL BETWEEN signed by the buriol-tronsit i REAP PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate couse (o), DUE TO stoting the underlying couse 19 WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(c) DR director, page 3 should be detached for use should be filed with the State Dept. of Health NO TO 200 ACCIDENT WAS UNDERLYING 20b DESCRIPE HOW INJURY OCCURRED (Enter nature of injury in Port I at Port II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) RELEASED 20c TIME OF INJURY Month, Doy, Year 20e PLACE OF INJURY (Home, form, (Stote) (City or town) (County) Haur a.m. foctory, street, office bldg., etc.) Nat While 21. I certify that (I) (this haspital) attended the deceased fram and that death occurred at 931AM, from couses and on the date stated above. saw the deceased alive an 226, AJGNAT JRE 22b. DATE SIGNED DIRECTOR PHYS. 22d ADDRESS PHYSICIAN S Silver NAME (Type) 9241 Columbia Blvd. 230 BURIAL, CREMATION, 23c. NAME OF CEMETERY OR CREMATORY 23b DATE THEREOF 23d. LOCATION (City or Town) (County) REMOVAL (Specify) Hartford Hartford Cemeters Joseph Gawler's Ash. VR A15 (4) 25M 1/67 Wisc. Ave. DATE



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 12686 The law requires that the death certificate be executed within 24 haurs after death. PLACE OF DEATH physician and completely filled in by the funeral en please-remove carban papers. Pages 1 and 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a COUNTY Montgomery o. STATEW. Virginia **b.** COUNTY MARYLAND b CITY OR TOWN (If autside corporate limits, CLENGTH OF STAY IN 15 c. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest tawn) Rural RURA, and give negrest town) Kearneysville d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS e. IS RESIDENCE ON A FARM? Rural Rt. # 28 YES NO [ 3 NAME OF First Middle Last 4 DATE Manth Year Day C. DECEASED ANNIE EPTEMBER (Type or print) 25 1967 DEATH IF UNDER 24 HRS S SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 8 DATE OF BIRTH AGE (In years IF LINDER I YEAR June 8, 1884 last birthday) Davs Haurs DIVORCED 1Da, US\_AL OCCUPATION (Give kind of work done 106 KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or fareign country) 12 CHLIZEN OF WHAT COUNTRYPISA during most of working life, even if retired) INDUSTRY W. Virginia 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME cremation, or removal, the attending phys James Haycock Hannah Ellis 17 INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO Address (Yes, no, ar unknown) (If yes give war ar dates of service) Gladys Dunn- Item # 2 232-74-2726 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN burial-transit PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) signed by DUF TO Canditians, if any, which gave rise ta immediate cause (a). DUF TO stating the underlying cause TO HOSPITAL OR ATTENDING PHYSICIAN: The law re Page 4 may be retained by the haspital or attending TO FUNERAL DIRECTOR: After this certificate has been as the PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? NO X μū 205, DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18) 20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 2Dc. TIME OF INJURY Manth, Day, Year 2Dd. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, form, (City or town) (State) 2Df. (County) factory, street, affice bldg., etc.) Nat While at wark at wark 21. I certify that (1) (this haspital) attended the deceased from\_ Mul 1967 to Asol 25, 1967, that (I) (we) last saw the deceosed olive on 2007 25 19 67, and that death occurred of 0300M, from causes and on the date stated above. 22a. SIGNATURE 22b, DATE SIGNED M.D. DIRECTOR 22d ADDRESS 22c. PHYSICIAN NAME (Type) John Fawcett Dawsonsville, Maryland director, should by 236 DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23a. BURIAL, CREMATION. REMOVAL(Specify) Bakersville Rakersville, Md. Me funeral Director Strider Company Charlestown, W. Va. 2So. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (4) 196 20 M 1/66





MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items #8 & 9 F12m #3392 9/13/2/ Pf1 CERTIFICATE OF DEATH 12688 The law requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, funstitution Residence before admission) physician and campletely filled in by the funeral en please remove-carban papers. Pages 1 and o. COUNTY b. COUNTY Montgomery Montgomery Maruland MARYLAND b CITY OR TOWN (If outside carparate limits, c CITY OR TOWN (If outside carparate limits, write RURAL and give nearest tawn) c LENGTH OF STAY IN 16 write RURAL and give nearest town) Kensington 17 415 Kensinaton d STREET ADDRESS d. NAME OF HOSP TAL OR INSTITUTION (If not in hospital, give street address) e IS RESIDENCE ON A FARM? 12609-Conn. Avenue 12609-Conn Ave. YES NO K remove carban 3 NAME OF Middle 4 DATE Month DECEASED Kudolph Frederick Sent vent\_ Sohaus. 19 67 (Type or print) DEATH SFX DATE OF BIRTH 9. AGE (In years IF UNDER I YEAR LIF LINDER 24 HRS 6. COLOR OR RACE 7. MARRIED NEVER MARRIED Aug. 30. 1897 Male WIDOWED 10a USUAL OCCUPAT ON (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired)
Interior Decorator Self employed COUNTRY? Missouri 13 FATHER S NAME 14 MOTHER'S MAIDEN NAME Henry Lohaus Iena Hagenberg IS WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT Address Kensington Md 16 SOCIAL SECURITY NO (Yes, no, or unknown) If If yes give war or dates of service) Loretta Lohaus-wife -12609-Conn. Ave. INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one cause per line far (a), (b) and (c) I-transit PART I. DEATH WAS CAUSED BY: signed by t burial-trans IMMEDIATE CAUSE (a) Conditions, if ony, which gave rise to immediate cause (o), DUE TO tar use as the t fHealthprior tat stating the underlying cause O FUNERAL DIRECTOR: After this certificate has been 19 WAS AUTOPS PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? NO K YES -20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 18.) 20o. ACCIDENT WAS UNDERLYING detached for OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e, PLACE OF INJURY (Home, form, (City or town) 20d INJURY OCCURRED (County) (Stote) TIME OF INJURY Month, Day, Year factory, street, affice bldg, etc.) Not While of work 21. I certify that (1) (this haspital) attended the deceased from 1967, that (1) (we) last 197.7, and that deoth occurred at 2 7PM, from couses and on the date stated obove saw the deceosed alive on 22g. SIGNATURE 22b. DATE SIGNED M.D DIRECTOR , page be filed 22d. ADDRESS 22c. PHYSICIAN S NAME (Type) Morris 11602-ya. Avenue Silver Spring. director, shauld b 230 BURIAL CREMATION, REMOVAL (Specify) 23c. NAME OF CEMETERY OR CREMATORY 23d EOCATION (City or Town) 23b DATE THEREOF (State) (County) Graceland Cemetery Mayville, Wisconsin Sept. 7. 1967 Charles Clister 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) Pumphrey Inc. 8434 Ga. Ave. S. S. Md. DATESFP 20 M 1/66

. . 4 .

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12690 CERTIFICATE OF DEATH PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. Slatt Maryland o. COUNTY Montgomery Prince Georges MARYLAND b CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) c CITY OR TOWN (If outside carparate amits, write RURAL and give nearest tawn) c LENGTH OF STAY IN 1b PHYSICIAN: The law requires that the death certificate be executed within 24 hours Bethesda Days College Park d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS e IS RESIDENCE Filled ON A FARM? The Clinical Center 6905 Carleton Terrace YES NO TX NAME OF Middle First 4. DATE Year DECEASED OF DEATH Bettv Zane Love September 1967 (Type or print) burial, crematian, ar remaval, and many event 9 AGE (In years last pirthdoy) SEX 6. COLOR OR RACE 8. DATE OF BIRTH IF UNDER 1 YEAR IF JNDER 24 HRS 7. MARRIED **NEVER MARRIED** White 14 November 1918 Female WIDOWED DIVORCED 10a USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired)
HOUS EWILT E 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT INDUSTRY DWY TEOME COUNTRY? New York 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME William Schofield Lottie Loehl 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANTThe Medical Recorders The Clinical 16. SOCIAL SECURITY NO (Yes, go, or unknown) (If yes give war or dotes of service) Not available Center, Bethesda, Maryland 20014 18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (r))
PART 1 DEATH WAS CAUSED BY INTERVAL BETWEEN ONSET AND DEATH Bacterial Sepsis IMMEDIATE CAUSE (a) \_ Page 4 may be retained by the haspital ar attending physician. 160 X DUE TO Canditions, if only, which gave (b) Soft Tissue Abscess 1 month rise to immediate couse (a), DUE TO stating the underlying cause this certificate has been 3 shauld be detached far use as the with the State Dept. af Health priar ta () Adenocarcinoma of lung with metastases vears PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1/3) WAS AUTOPSY PERFORMED? YES X NO 200 ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I) of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, form, (City or town) (County) (State) foctory, street, office bldg., etc.) Not While at work of work 21. I certify that (1) (this hospital) attended the deceased from 15 August, 1967, to 30 September 67 that (1) (we) lost saw the deceased alive an 30 September 1967, and that death accurred at 3:25 M, from causes and an the date stated above. 22a SIGNATURE 22b. DATE SIGNED **ATTENDING** STAFF X Sept. 30, 1967 director, page 3 should be filed v DIRECTOR PHYS. minal 22d ADDRESS The Clinical Center, National 22c. PHYSICIAN S NAME (Type) Thomas P. Clancy, M.D. Institutes of Health, Bethesda, Md. 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23b DATE THEREOF 23o BURIAL CREMATION, Gate of Heaven Cemetery Silver Spring, Paruland 2 OCT 4 1967 Glen Carter 8434 Gersagia Avenue VR A15 (4) Pumphrey, Inc. Silver Spring, Md.



OF HEALTH

TANADA HATE SULLY CAMA

1:	1 3	101	MARYLAND STATE DEPARTMENT OF HEALTH  Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
	7		12583 CERTIFICAT	E OF DEATH	12	2692		
offer leath	Pages 1 and 2 urs after death		PLACE OF DEATH  b. COUNTY  COUNTY  MARYLAND  CITY OR TOWN (If outside carparate limits.  write/RURA. ond give nearest town)  C. LENGTH OF STAY IN 16	c CITY OR TOWN (It autofoe	corporate limits, write RURAL and give	wigomeny		
in 24 hav	d in b		Uncator  d Name Of HOSPITAL OR INSTITUTION (If not in hospital, give street address)  University Nursing Home	d STREET ADDRESS 2009 Blue	eridge Ave	B IS RESIDENCE ON A FARM? YES NO		
cuted with	carbor carbor ent, wi	5	NAME OF DECEASED  (Type or print)  (Type or print)  (A. COLOR OR RACE 7. MARRIED NEVER MARRIED	8 DATE OF BIRTH	DEATH  9 AGE (In years IF UNDER 1 Months)  Months	Day Year  2 19 6 7  YEAR IF UNDER 24 HRS. Days Hours Min.		
ate be exe	physician and cam hen please remove naval, and infanyer	dui	USUAL OCCUPATION (G ve kind of work done ng most af working life, even if retired)  Homemaker  FATHER'S NAME	10/16/1898 11 BIRTHPLACE (County & Stot) Rochester 14 MOTHER'S MAIDEN NAME	te or foreign country) 12. CT	ZEN OF WHAT UNTRY?		
leath certific	permit. Then ian, ar remaval		Me GER Markowitz WAS DECEASED EVER IN US ARMED FORCES? 16. SOCIAL SECURITY NO. 17	Rachel	With Records			
OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 be retained by the hospital or attending physician	signed by the burial-transit burial, cremat		18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave (a) (b)  HYPOTE	SCULAR HER	NORRHAGE	INTERVAL BETWEEN ONSELAND DEATH OF THE STATE		
.N: The faw re or attending	ate has been ar use as the lealth priar to	CERTIFICATION /	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO	THE TERMINAL DISEASE CONDITION	ON GIVEN IN PART I(a)	19 WAS ALTOPSY PERFORMED? YES NO		
IG PHYSICIA	ar this certific detached for the Dept. of H	MED CAL CERT	OR CONTRIBUTING   (IF EITHER, NOTIFY MEDICAL EXAMINER)  20c. TIME OF INJURY Monih, Doy, Yeor  20d. INJURY OCCURRED  20e. PL	LACE OF INJURY (Home, farm, ctary, street, affice bldg., etc.)	20f. (City ar town) (Cou	inty) (State)		
TAL OR ATTENDING PHYSICIAN	O FUNERAL DIRECTOR: After this certificate has been director, page 3 should be detached far use as the should be filed with the State Dept. of Health prior to		21. I certify that (I) (this haspital) attended the deceased fram_saw the deceased alive an	at death occurred at	TAM, fram causes and on the CTOR STAFF 226. DA	ne date stated above		
•	TO FUNER (F) 51V W G (F) 51V W G Should b	23/19/0			SYRACUSE.	(County), (Stote)  GNATURE  Les Junge		



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12693 CERTIFICATE OF DEATH PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY b. COUNTY MARYLAND b CITY OR TOWN C LENGTH OF STAY IN 15 c CITY OR TOWN (If outside carporate limits, write RURAL and give negrest town) perside comprote write RtIRAL and give near (If not in hospital, give street address) ON A FARMS YES NO 132 3. NAME OF Middle DATE Year DECEASED OF DEATH Type or print) SEX 9. AGE (In years Sast birthdoy) IF UNDER 24 HRS 7 MARRIED NEVER MARRIED Months WIDOWED DIVORCED 100 USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR BIRTHPLACE (County & State, or foreign country) 12 CIT ZEN OF WHAT during most of working life, even if retired)

Housewife INDUSTRY COUNTRY? 13. FATHER'S NAME 14. MOTHERS MAIDEN NAME or removal, Mary Florrie Lov (Yes, no, or unknown) (If yes give wo in dates of service) Address Same as Item 2. INFORMANT Husband - McAuliffe 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY. STROKE IMMEDIATE CAUSE (o). DUE TO Canditions, if any, which gove PERTENSIUW + CURONARY DISTASE rise to immediate couse (a), DUE TO stating the underlying couse PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE COND T ON GIVEN IN PART 1(a) 19 WAS AUTOPSY PERFORMED? YES [ NO F 20o ACCIDENT WAS UNDERLYING I 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port 1) of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, form (City or town) (County) (State) Haur o.m. factory, street, office bldg., etc.) Not While at work 2]. I certify that (1) (this haspital) attended the deceased from 1955, 10 Day , 19,67, that (I) (we) last Bur 2 199, and that death accurred at 942 M, from causes and on the date stated above. saw the deceased alive an-220. SIGNATURE 22b. DATE SIGNED orriva DIRECTOR MD 22c. PHYSICIAN S 22d. ADDRESS DONOVAN NAME (Type) BETHENDA WIJC, Adr 230 BURIAL CREMATION. 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) REMOVAL (Specify) Monocacy Cemetery Beallsville maryland
REGISTRAR | 256 REGISTRAR'S SIGNATURE 9-5-67 24. FUNERAL DIRECTOR 2So REC'D BY REGISTRAR VR A15 PUMPHREY, Bethesda, Maryland DATESEP 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12985 12694 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution Residence before admission) COUNTY onteomeri MARYLAND The law requires that the death certificate be executed within 24 hours after b CITY OR TOWN (If outside corporate amits, c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give negrest town) and campletely filled in by d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) IS RES DENC ON A FARM? NO SC Middle carban Year OF DEATH DECEASED Sept. 19 67 burial, crematian, ar removal, and in any event, (Type or print) AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS **NEVER MARRIED** durthday) WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & Stote, or foreign country) 12 CITIZEN OF WHAT 13. FATHER'S NAME MOTHER'S MAIDEN NAME 17. INFORMANT Daug. 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO Same as Item 2. (Yes, no, or unknown) (If yes give wor or dotes of service) Harriet Hercher INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). signed by the burial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY ARTERIO SCLERCT IMMEDIATE CAUSE (o) Page 4 may be retained by the haspital or attending physician. 4200 DUF TO Conditions, if any, which gove 3 ARTERIOSCEROSIS rise to immediate couse (o). DUE TO stoting the underlying couse detached far use as the e Dept of Health priar ta O FULLRAL DIRECTOR After this certificate has blien WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(d) NO 🔀 20a ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port II of Item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e PLACE OF INJURY (Home, form, 20d INJURY OCCURRED (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year Hour o.m. foctory, street, office bldg. etc.) 1964 10 SEPT. 21. I certify that (I) (this haspital) attended the deceased fram. 1967, that (I) (we) last director, page 3 shauld shauld be filed with the 19.67, and that death accurred at 4:90pM, fram causes and an the date stated above. saw the deceased alive an\_ 220 SIGNATURE 22b. DATE SIGNED ATTENDING M.D. DIRECTOR 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) 230 BURIAL, CREMATION 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (Stote) (County) REMOVAL (Specify) St. Lawrence Cemetery 9-20-67 New Haven thesda, 2So REC D BY REGISTRAR FUNERAL DIRECTOR VR A15 (4) 1967

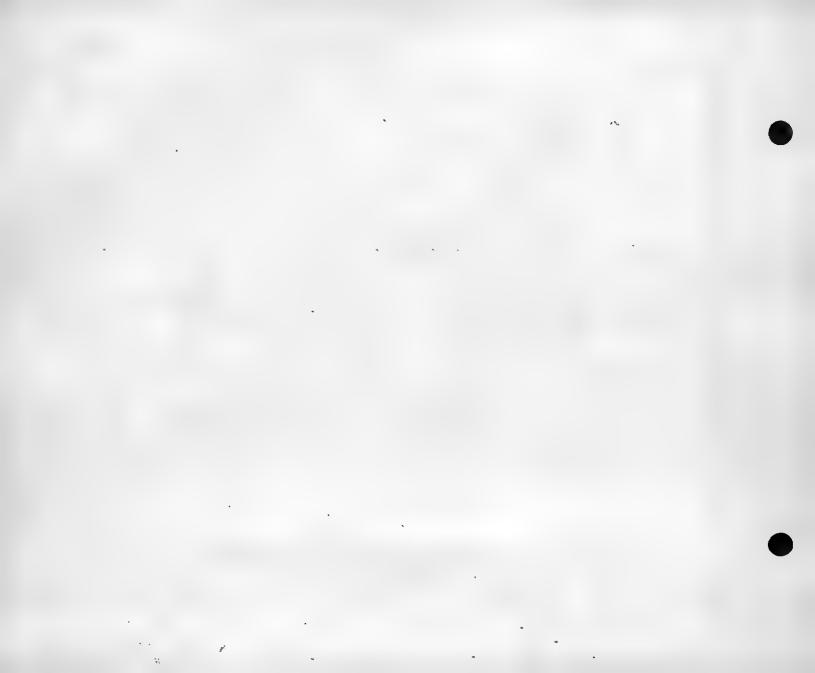


DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12695 12686 CERTIFICATE OF DEATH The taw requires that the death certificate be executed within 24 haurs after death. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. COUNTY b. COUNTY Montgomary Montgome ry MARYLAND CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLENGTH OF STAY IN 16 c CITY OR TOWN (If autside corporate amits, write RURAL and give negrest town) Hin 72 hours of Silver Spring. Bethesda .⊆ d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS IS RESIDENC filled ON A FARM? 10110 New Hampshire Ave Suburban Hospital NO NAME OF 4. DATE Doy Year campletely OF DEATH DECEASED 19 57 McGLELLAND Sept. vent, PAUL.  ${f WILLIAM}$ (Type or print) 6 COLOR OR RACE JE LINDER 7 MARRIED **NEVER MARRIED** DATE OF BIRTH 9 AGE (In years Oct.27,1918 49 birthdoy) White Male WIDOWED DIVORCED puo 10o, USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & Stote, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY **COUNTRY?** S. Penna. 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME burial, crematian, ar remaval, Mary G. Brady Daniel Clark McClelland IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT wife Address Same as Item 2. (Yes, no, or unknown) (If yes give wor or dotes of service) 72-16-1310 Amelia R.McClelland 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c) INTERVAL BETWEEN burnal-transit PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) þ Page 4 may be retained by the haspital or attending physician DUE TO Conditions, if any, which gove rise to immediate couse (a). DUE TO stoting the underlying couse af for use as the PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS ALTOPS PERFORMED? YES 3 certificate NO F 200 ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Port 1( of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 20¢ TIME OF INJURY Month, Doy, Year (City or town) (Stote) Hour om factory, street, office bidg, etc.) While at work DIRECTOR: After be 21. I certify that (1) (this hospital) attended the deceased fram and that death accurred at 120 A. M. fram causes and on the date stated above saw the deceased alive an 220 SIGNATURE 22b DATE SIGNED director, page 3 should be filed v DIRECTOR 8218 Wisconsin Ave. 22c. PHYSICIAN S O FUNERAL NAME (Type) Bethesda, Maryland 23o. BURIAL REMATION. 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (State) Burlal (Specify) New Bethlehem Cometery New Bethelhem, Pennia 9-12-67 24 FUNERAL DIRECTOR **ADDRESS** 2So REC'D BY REGISTRAR 2Sb REGISTRAR'S SIGNATURE VR A35 (4) 25M 1/67 Bethesda, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12696 CERTIFICATE OF DEATH PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) · COHNTY MONTGOMERY Montgomery MARYLAND law requires that the death certificate be executed within 24 haurs after O FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 shauld be detached for use as the burial-transit permit. Then please remave carbon pagers Pages should be filed with the State Dept. of Health priar to burial, crematian, ar removal, and in any event, within 70 hours after CITY OR TOWN (If autside corparate limits, write RURAL and give nearest fawn) b CITY OR TOWN (If outside carparate limits, CLENGTH OF STAY IN 16 write RURAL and give nearest town) Silver Spring Silver Spring 6 years d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? 10703 Jenbrook Drive Tenbrook Drive YES NO IR NAME OF 4. DATE Middle Last Month Day Year DECEASED OF DEATH 5211 I'la Jutiro 19 4 (Type or print) SEX DATE OF BIRTH AGE (In years F UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED **NEVER MARRIED** last birthday) Months Hours Male WIDOWED DIVORCED April 12, 1897 12. CITIZEN OF WHAT Too USJAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or fareign country) COUNTRY? during most of working life, even if retired). Letized Iccount and Gou to Ohio 14 MOTHER'S MAIDEN NAME 13 FATHER S NAME William Scott Mc Intire Olive Modesett WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT 10703 JenBrook Drive Silver Spring, Maryland OA ues INTERVAL BETWEEN ONSET AND DEATH IB. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: UDCArdi IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gove nse to immediate cause (o), **DUE TO** stating the underlying cause last 19 WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? NO. YES 200 ACCIDENT WAS UNDERLYING 205, DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Port I or Port I) of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER Dept. 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form. (City or Town) (County) (Stote) 20c. TIME OF INJURY Month, Day, Year Hour o.m. factory, street, affice bldg., etc.) Not While O HOSPITAL OR ATTENDING 21. I certify that (I) (this huspital) attended the deceased from aug . 1967, to Celep 25, 1967, that (1) (we) last 1967, and that death accurred at 2304 M, from causes and an the date stated above. saw the deceased alive an 22a SIGNATURI 22b DATE SIGNED DIRECTOR director, page 3 should be filed v PHYS 22d ADDRESS 22c PHYSICIAN S NAME (Type) PDFG 23a BURIAL, CREMATION 23c. NAME OF CEMETERY OR CREMATORY REMOVAL (Specify) Parklawn Cemetery Rockville. l'aryland Glen Carter 24 34 ADDRESS raia Avenue 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE VR A15 (4) Pumphrey.



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12885 12697 CERTIFICATE OF DEATH PHYSICIAM: The law requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) · COUNTY Montgomer b. COUNTY MONITOCONTRY o. STATE MARYLAND the b CITY OR TOWN (If outside corporate limits. c LENGTH OF STAY IN 16 c CITY OR TOWN (If purside corporate limits, write RURAL and give nearest town) 1 week completely filled in by OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS IS RES DENCE ON A FARM? carban papers within) NO DO DATE DECEASED OF DEATH burial-transit permit. Then please remave cart burial, cremation, ar remaval, and in any event, (Type or pnnt) 6. COLOR OR RACE 9. AGE (In 7. MARRIED NEVER MARRIED lost berindoy) 2-6-84 DIVORCED WIDOWED and 199 USLAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stole, or foreign country) 12 CITIZEN OF WHAT dereignest of working live want retired) signed by the attending physician obviral-transit permit. Then please tcher ONMECTACUL 13. FATHER S NAME 14 MOTHER'S MAIDEN NAME 15 WAS DECEASED EVER AS L. S. ARMED FORCES? (Yes, no, or unknown) (M yes give wor or dotes of service) 16. SOCIÁL SECURITY NO 042-05-3934 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (o) Page 4 may be retained by the haspital or attending physician. DUE TO Conditions, if any, which gove nse to immediate couse (a) DUE TO stoting the underlying couse the director, page 3 shauld be detached far use as the shauld be filed with the State Dept. af Health priar to certificate has been PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT REPAYED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS ALTOPS PERFORMED? ΝO 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of njury in Port I or Port II of item 18) 20o ACCIDENT WAS UNDERLYING IT OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MED CAL EXAMINER) 20e PLACE OF INJURY (Home, form, 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED (Crty or town) (County) FUNERAL DIRECTOR: After this Hour om. Not While foctory, street, office bldg, etc.) of work deceosed from 11-14, 1965, to 1967, that (1) (we) last 1967, and that death accurred at 21-M, from couses and on the date stated above. 21. 1 certify that (1) (this haspital) attended the deceased from 11-14 saw the deceased alive on 22b DATE SIGNED 220. SIGNATURE DIRECTOR 22 PHYSICIAN'S 22d. ADDRESS NAME (Type) CY 23c NAME OF CEMETERY OR ENEMPTORY 23d. LOCATION (City or Town) BUR AL, CREMERON, 23b DATE THEREOF (County) (Stote) Al (Specify) 2 REC'D BY REGISTRAR 25b REGISTRAR 5 SIGNATUR ave VR A15 (4) 25M 1/67 DATE SEP



Year

I IF UNDER 24 HRS

INTERVAL BETWEEN

ONSET AND DEATH Weeks

1 month

vears

19 WAS AUTOPSY PERFORMED? YES X NO

(State)

19 67

23

U.S.A.

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. by the funeral papers. Pus completely filled within carban physician c sen please ar remayal, burial-transit p the haspital ar O FUNERAL DIRECTOR: After be retained by

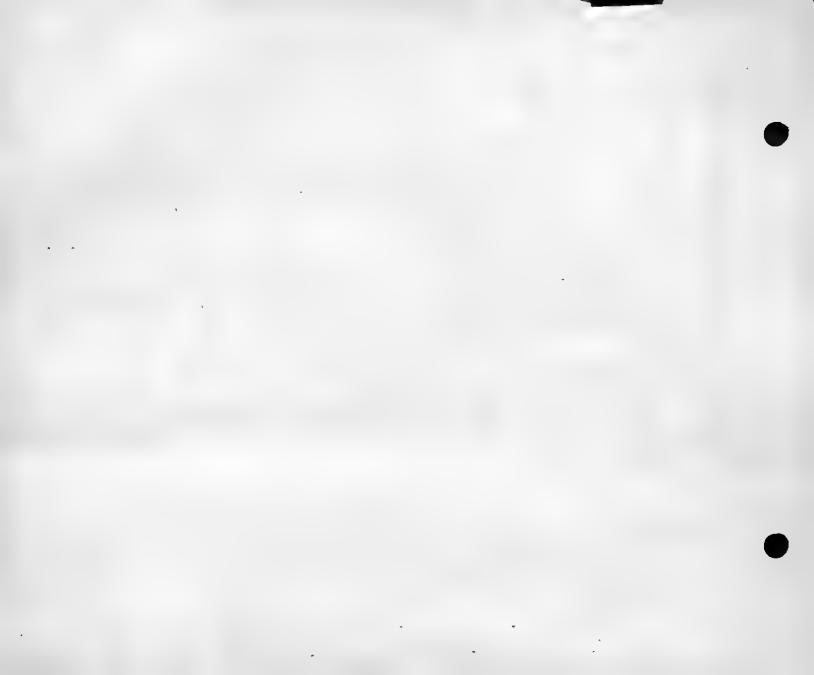
12585

PLACE OF DEATH a. COUNTY Montgomery b CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) Bethesda d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 20074 The Clinical Center, Bethesda, Maryland 4 DATE DECEASED OF DEATH Michael Shawn Mearns September (Type or print) SEX 6. COLOR OR RACE 9 AGE (In years IF JNDER 1 YEAR 8 DATE OF BIRTH 7 MARRIED **NEVER MARRIED** last birthday) Male White WIDOWED DIVORCED 26 November 1962 10a JSUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12 CITIZEN OF WHAT 11 BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired)
Child (None) INDUSTRY Indiana 13 FATHER 5 NAME 14. MOTHER'S MAIDEN NAME William E. Mearns Veda A. White 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no. or unknawn) (If yes give war or dates af service) 16. SOCIAL SECURITY NO 17. INFORMANT The Medical Records The Clinical Center, Bethesda, Maryland 20014 None 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY-IMMEDIATE CAUSE (a) Herpes encephalo-myelitis DUE TO Canditians, if any, which gave 1 (b) Aspiration pneumonitis rise to immediate cause (a), DUE TO stating the underlying cause (a) Acute lymphocytic leukemia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 20g ACCIDENT WAS UNDERLYING [ 20b DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of tem 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL 20c TIME OF INJURY Manth, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, farm, (City or town) (Caunty) Nat While factory, street, affice bldg., etc.) 21. 1 certify that (1) (this haspital) attended the deceased from July 31 1967, to Sept. 23, 1967, that (1) (we) last saw the deceased alive on Sept. 23 1967, and that death accurred at 9:40 M, from causes and an the date stated above 22a. SIGNATURI 22b DATE SIGNED ATTENDING STAFF Sept 23, 1967 M.D. DIRECTOR PHYS 22c PHYS CIAN S 22d ADDRESS The Clinical Center, National NAME (Type) Charles M. Haskell, M.D. Institutes of Health Bethesda Md. 2001

23d LOCATION (City or Town) 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23a BURIAL, CREMATION, REMOVAL (Specty) 9-27-67 Sunset Memorial Park Charleston W. Virginia 250 REC'D BY REGISTRAR DASEP 29 19 2Sb REGISTRAR'S SIGNATURE Pumphrey 7557 VR A15 (4) 25M 1/67 Milayer Judes



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12699 CERTIFICATE OF DEATH and 2 death. er death runeral PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) p. COUNTY b. COUNTY Montgomery Montgomery Maryland MARYLAND b CITY OR TOWN (If outside corporate limits. c LENGTH OF STAY IN 15 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) haurs Silver Spring Silver Sprina day d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d STREET ADDRESS S RES DENCE ON A FARM? hin 72 \*Daper filled 1303 Morningside Drive Cross Hospital YES NO 7 OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within NAME OF Middle 4. DATE DECEASED OF DEATH ve cor (Type or print) Geronce 6 COLOR OR RACE 7 MARRIED AGE (In-yet) IF UNDER I YEAR NEVER MARRIED lost birthdon) Months Dovs Hours WIDOWED DIVORCED lune 27 rem 6 100 USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State or Foreign country) 12 CIT ZEN OF WHAT physician a during most of working life, even if retired) INDUSTRY and Providence, Rhode Island Housewite (wn. Home 13 FATHER S NAME remayal Katherine Tierney Parrell C. Pitzpatrick attending p WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT Morning Side Drive Wer Spring, Maryland 16 SOCIAL SECURITY NO permit. (Yes, ng, or unknown) (If yes give wor or dates of service) Б John Mechan ues. cremation, 18 CAUSE OF DEATH (Enter only one couse per line to; (o), (b), ond (c).)
PART 1 DEATH WAS CAUSED BY: INTERVA, BETWEEN signed by the burial-transit ONSET AND DEATH IMMEDIATE CAUSE (o) be retained by the haspital ar attending physician. DUE TO burial, Conditions, if any, which gave 1 (b) rise to immediate couse (a), DUE TO stoting the underlying couse far use as the l Health priar ta b this certificate has been PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) WAS AUTOPSY PERFORMED? NO 200 ACCIDENT WAS UNDERLYING [ 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 1 of item 18) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER Dept. ( 20c TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour om should be det While Not While foctory, street, office bldo., etc.) ot work at work O FUNERAL DIRECTOR: After 21. I certify that (1) (this hospital) attended the deceased from... saw the deceased alive on and that death occurred at 3024-M, from causes and on the date stated above 229. SIGNATURE 22b\_DATE SIGNED STAFF PHYS. director, page 3 should be filed v MD DIRECTOR PHYS TO HOSPITAL (Page 4 may b 22c.-PHYSICIAN'S 22d ADDRESS NAME (Type) BURIAL CREMATION. 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (State) REMOVAL (Specify) St. Trancis Cemetery Pantucket. Rhode Island 250 RECD BY REGISTRAR 256 REGISTRAR S SIGNATURE 8434 ADEGraia Avenue VR A15 (4) DATE SEP 11 1987 25M 1/67 Silver Spring.



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12697 12700 CERTIFICATE OF DEATH When in by the funeral papers. Pages 1 and 2 deoth. requires that the death certificate be executed within 24 hours after death PLACE OF DEATH USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) o STATE Maryland a. COUNTY b. COUNTY Montgomery Montgomeru MARYLAND h. CITY OR TOWN (If autside carparate mils, c. LENGTH OF STAY IN 16 c CITY OR TOWN (If guitside corporate limits, write RURAL and give negrest town) write RURAL and give nearest tawn) Silver Spring ON A FARM?

VES NO d NAME OF HOSP TALLOR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS 815 Brantford Avenue Suburban Hosnital g physician and completely full NAME OF 4 DATE Middle Last Manth Day Year DECEASED Harold Meeth September (Type ar print) DEATH 4 67 AGE (In years IF UNDER I YEAR TIE UNDER 24 HRS S. SEX 8 DATE OF BIRTH 6 COLOR OR RACE 7 MARRIED NEVER MARRIED last birthday) Haurs Male White WIDOWED DIVORCED 10a, JSUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State or foreign country) 12 C TIZEN OF WHAT during most of working life, even if retired **NDUSTRY** COUNTRY? Retired Jost O Baltimore. .3 FATHER S NAME 14. MOTHER'S MAIDEN NAME the attending phys John Tenry Meeth Martha Frincke IS. WAS DECEASED EVER IN J.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMANT Address brantford Hye. (Yes, na, ar unknown) (If yes give war ar dates of service) 218-26-1803 Charlotte Bayln Meeth ONSET AND DEATH 1B CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).)
PART I, DEATH WAS CAUSED BY signed by the buriol-transit p IMMEDIATE CAUSE (a) DUF TO Conditions, if any, which gave rise to immediate cause (a), DUE TO stating the underlying cause as the prior to O FUNERAL DIRECTOR: After this certificate hos been PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPS!
PERFORMED? of Health NO P Ď 20g. ACC, DENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Hame, form, (City or town) (County) (State) Not While factory, street, affice blda., etc.) at wark 21. I certify that (I) (this hospital) attended the deceased from Man Poge 4 may be retained and that death occurred at 1-3 of the from causes and an the date stated above. saw the deceased alive an - 196 22a. SIGNATURE 22b. DATE SIGNED M.D. DIRECTOR 22c PHYSICIAN'S 22d. ADDRESS TO HOSPITAL director, par NAME (Type) 9006 Colesville Road 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23a. BUR AL, CREMATION, 23b DATE THEREOF REMOVAL (Specify) nce yeardes 25a, REC'D BY REGISTRAR 2Sb REGISTRAR'S SIGNATURE Carton 8434 appriss and Huenne VR A15 (4) 1967 DASEP Inc. Silver Spring, Md. 20 M 1/66



2-10	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND						
(M)	CERTIFICATE OF DEATH 12701						
fundament death.	1. PLACE DF DEATH M						
hours after  i by the first Pages 1  thours after	b. CITY OR TOWN (if outside corporate limits, C. LENGTH OF STAY IN 1b c. CITY DR TOWN (if outside corporate limits, write RURAL and give nearest town)						
hours a	write RURAL and give nearest town)  Taloma Park  d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)  d. STREET ADDRESS  d. STREET ADDRESS  G. STREET ADDRESS  ON A FARM?						
n 24 fille paper hin 72	RALLS NURSING HOME 74924 MAPLE MINE / TOKUMA JUST NOT						
exected within 24 hour and completely filled in remove carbon papers.  Any event, within 72 hour any event, within 72 hour any event,	3. NAME DF FIRST Middle Last 4. DATE Month Day Mear (Type or print) CATHERINE H MENdum DEATH 9 26 1967						
executed and compression of the	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years   FUNDER 1 YEAR   FUNDER 24 HRS.						
X France and X	WIDOWED DIVORCED 5-17-1890 77 yrs.  10a. USUAL OCCUPATION (Give kind of work done during, most of working life, even if retired) INDUSTRY  11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY?						
death certificate lef execut the attending physician and of permit. Then please remove ation, or removal, and in any e	during most of working life, even if retired) INDUSTRY  13. FATHER'S NAME  14. MOTHER'S MAIDEN NAME						
ertific ling p Then emova	JOSEPH C. HALLIEY CATHERINE REUTTER						
ath continuit.	18. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address Take of Service) (Yes, mo, or unknown) (If yes give war or dates of service)						
aw requires that the deat tending physician. has been signed by the at as the burial-transit perm prior to burial, cremation,	18. CAUSE OF DEATH [Enter only one cause per time for (a), (b), and (c), ]  PART I DEATH WAS CAUSED BY.  ONSET AND DEATH						
that the ician, ned by I-trans	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  DUE TO  DUE TO						
ulres phys phys purial purial purial	Conditions, if any, which are rise to immediate (b) Haterioscienos						
law requirements that the last pee	cause (a), stating the DUE TO underlying cause last. (c).						
The lar or att ate ha	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES 100-100-100-100-100-100-100-100-100-100						
HYSICIAN: The he hospital or a this certificate tetached for use i Dept. of Health	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  PERFORMED?  YES NO  OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						
OK ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.  JIRETOR: After this certificate has been signed by the attending physics 3 should be detached for use as the burial-transit permit. Then ple detached for use as the burial-transit permit. Then ple and with the State Dept. of Health prior to byrial, cremation, or removal, and the state Dept. of Health prior to byrial, cremation, or removal, and the state Dept. of Health prior to byrial, cremation, or removal, and the state Dept.	20c. TIME OF INJURY Month, Day, Year   20d. INJURY OCCURRED   20e. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.)   20f. (City or town)   (County)   (State)   20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.)   20g. PLACE OF INJURY (Home, farm, factory						
ATTENDIN etained to STOR: Aff should b ith the St	21. I certify that (I) (this hospital) attended the deceased from 9/19, 196 to 9/26, 196, that (I) (we) last						
or ATTENE y be retaine DIRECTOR.	saw the deceased alive on 196, and that death occurred at AM, from the causes and on the date stated above.  22a. SIGNATURE  ATTENDING MED. STAFF 9/2 (2)						
	22c. PHYSICIAN'S DIRECTOR PHYS. 22d. ADDRESS						
O HOSPITAL OKATTEND Para 4 may be retained O FUNERAL DIRECTOR. 4 director, page 3 should should be filed with the	NAME (Type)  23a. BURIAL, CREMATION, 23b. DATE THEREOF   23c. NAME OF CEMETERY OR CREMATORY   23d. LOCATION (City, town or county) (State)						
or or its day	Complex 9-26-67 9. Wm Les + Sans 300 4th SX NE. Work DC						
VR A15 (4) 15M 4-64	24. FONERAL DIRECTOR  LEG I-VNSKOL HOME 300 F STUE DATE SEP 2 1969. REGISTRAD SEP. REGISTRAD SEP						



STATISTICAL RESEARCH A RESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where decessed fived, if institutions Residence before edmission) a. COUNTY b. COUNTY Montgomery MARYLAND 90meRU b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 (If outside corporate limits, write RURAL and live nearest top write RURAL end give nearest town! Rockville -Aithers burg days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) a. IS RESIDENCE ON A FARM? 429 Nursing Home East YES NO X Diamond Avenue NAME OF DATE Year DECEASED OF (Type or print) DEATH 19 5. SEX B. DATE OF BIRTH IF UNDER 7. MARRIED X NEVER MARRIED I 9. AGE [In years] death certificate be last birthday) Months | Days WIDOWED [ 8, 1887 DIVORCED Jan. remove 10a. USJAL OCCUPATION (Give kind of work 106. KIND OF BUSINESS OR INDUSTRY BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? done duping most of working, ife, even if retired) HOUSewire Home Fairfax County, Va. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME William A. Moxley Susan Ellen Riley 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT (Yes, no, or unknwn) [ (If yes give wer or deles of service) E. Diamond Harry C. Merry. None thersburg. Md. 18. CAUSE OF DEATH [Enter only one cause per line for ,e), (b), and (c) ONSET AND DEATH PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (e) DUE TO Conditions, if any, which geve rise to immediate ceuse DUF TO (e), stating the underlying cause lest. PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(8) 19, WAS AUTOPSY PERFORMED? NO K 20s, ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part It of Item 18.) OR CONTRIBUTING | CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY 2Dd. INJURY OCCURRED 20e. PLACE OF INJURY (Home, ferm, Month, Day, Yeer 2Df. (City or lown) (County) (State) lactory, street, office bldg., etc.) While Not While Hour e.m. of work | et work p,m. saw the deceased and that death occured at....... M, from the causes and on the date stated above; 22e. SIGNATURE 22b. DATE 967 SIGNED ATTENDING STAFF PHYS, DIRECTOR PHYS. 22c. PHYSICIAN S 22d ADDRESS Battery Lane, Bethesda, Md. Joyce: M. D. 23e. BURIAL, CREMATION 1 296 DATE THEREOF NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (Steta) 0 24 FUNERAL DIRECTOR'S SIGNATI 1 256. REGISTRAR'S SIGNATURE 25a. REC'D BY REGISTRAR VR A35 (4) 15M 7 61



- I	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MA	RVI AND
FOR STATE	12594 - MEDICAL EXAMINER'S CERTIFICATE OF DEATH	12703
HEALTH DEPT	1. PLACE OF DEATH a. COUNTY a. STATE b. COUNTY	
253	Montgomery  MARYLAND  West Virginia  b. CITY OR TOWN (If outside corporate limits, I c. LENCTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL	and also passed town
cessary, e funeral e 5 may be Department after death.	write RURAL end give nearest town)	and Blan nearest touri
S E Le L	Rural - Bethesda Great Cacapon  d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)  d. STREET ADDRESS	e. IS RESIDENCE
EXAMINER: This certificate should be executed within 24 hours after death. If any delay a certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 is should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page files.  TOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Diesignated agent, prior to burial, cremation, or removal, and in any event without 78 hours at	Route 270	YES NO
ny del	3. NAME DF First Middle Lest 4. DATE Month OF	Day Year
802 E	(Type or print)	6 1967
2 with with with with with with with with	Jast birthdey) Months	Days Hours   Min.
leatil Pag th 1 inf 2	Female Cauc. WIDOWED DIVORCED XOC, 14, 1931 35 37 yrs. 10e, USUAL OCCUPATION (Cive kind of work done) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CI	TIZEN OF WHAT
ter deal Sive Pag Sive Pag With 1 and 2	during most of working ilfo, even if retired) INDUSTRY However Il est burgenea	UNITRY A
urs aft n 18. G along pages in any	13. FATHER'S NAME, 14. MOTHER'S MAIDEN NAME	
1 E 2 2 E 4 E 4 E 4 E 4 E 4 E 4 E 4 E 4 E	France C. Yourstlord Core R. Whiener	
24 ho n Item Office File	15. WAS DECEASED EVER INV.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or uniform) (If yes place war or dates in service)	
hin cit in wit.	Hospital Riverds	
within pencil ir miner's permit.	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	ONSET AND DEATH
Exal Exal or	PART I. DEATH WAS CAUSED BY: Injuries multiple severe	Seconds
uld be executed "pending" in "pending" in the Medical Example of the	DUE TO	C
be e pend ledi irial	Conditions, if eny, which gove rise to immediate (b) Truck accident	Seconds
a be	cause (e), steting the DUE TO underlying cause last.	
sho Chi as arial	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0)	19. WAS AUTOPSY
frate shou the word of the Chief used as a to burial,	None	PERFORMED?
or to	None  20a. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING Passenger in cab of tractor trailer which ran in abutment at high speed. Gasoline tank exploded a	to bridge
is ce mritti graded buld prid		nd truck
R. This crate, writense forward 3 should agent, p	C factory street office bldg atc	nty) burnedute)
NER fifica be f ge 3		omery Md.
Par Par mate	21. I certify that I took charge of the remains described above, held an Autopsy X, Inspection X, Inquiry ,	and in my opinion
EXA shoul files. TOR: esign	death resulted from: Natural causes, Accident _X, Suicide, Homicide, Undetermined manner	
4 Pig 33 S	ACTUAL CHIEF MEDICAL EXAMINER CHIEF CHIEF MEDICAL CHIEF CHIE	22. DATE SIGNED
ME: Gecut Page 4 for your L DIREC or its d	SIGNATURE	9/6/67 minary Rd.
TO DEPUTY MET EXAMINE please execut a certific director. Page 4 should be retained for your files.  TO FUNERAL DIRECTOR: Page of Health or its designated	EXAMINER'S John S. Rogers, M.D.  Address (Street, city, town or county) Silver	Spring, Md.
DEPUTY please en director. retained O FUNERA of Health	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OF CREMATORY 23d. LOCATION (City, town or con	inty) (State)
7 gg 2 2 5	Burial Sept 10 Alt: Miles Einstein Morian Gunty	1.000
VR AISME (5)	24. FUNERAL DIRECTOR 250. REGISTRARY 250. REGISTRARY	S SICNATURE
5M 1/65	Later SEP 4 1 1961 Journ	0 0 -



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12995 MEDICAL EXAMINER'S CERTIFICATE OF DEATH **FOR STATE** 12704 HEALTH-DEPT. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission. a. COUNTY a. STATE b. COUNTY MARYLAND mon 190mery OR TOWN (If autside carparate limit: OR TOWN (If autside carparate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 de Twrite RURA, and give negrest tow E W d d. NAME OF HOSPITAL OR INSTITUTION e. IS RESIDENCE (If not in haspital, give street address) d STREET ADDRESS farm ON A FARM the certificate, writing the ward "pending" in pencil in Item 18. Give Pages 4 should be farwarded to the Chief Medical Examiner's Office along with far NO F be executed within 24 hours ofter death NAME OF Middle DATE Manth First Lost Doy Year DECEASED 0F (Type or print) 190 DEATH buria.-transit permit. File pages 1 and 2 with S SEX 6 COLOR OR RACE 7 MARRIED B DATE OF BIRTH AGE (In years IF JNDER 1 YEAR IF UNDER last birthday) Manths Days Hours event within 72 haurs after death. WIDOWED -1900 DIVORCED 10b, KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT during-most of working life, even if retired) CAO IN **CQUNTRY?** Salesmai KUS51a 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME UNKnowsk - (0000. 15 WAS DICEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO **INFORMANT** Address (Yes, an arunknawn) (If yes a ve war ar dotes of service) 1B. CAUSE OF DEATH (Enter only one cause per lyst INTERVAL BETWEEN PART I DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (a) This certificate should DUE TO (and tons, if any, which gave nse ta immediate cause (a), .= DUE TO stating the underlying cause oug be used 19 WAS AUTOPSY PERFORMED? remayal PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE COND T ON GIVEN IN PART 1(6) CERTIFICATION NO 20d EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 3 should ä PRIMARY C or CONTRIBUTING C CAUSE OF DEATH crematian, 20c TIME OF NJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF NJURY (Home, farm (City or town) (Caunty) (Stote) Haur a m. factory, street, office bldg., etc.) Not While at work 21. I certify that I took charge of the remains described above, held on Autapsy Inspection and in my apinion FUNERAL DIRECTOR: Notural couses death resulted for Accident Suic de d.rectar Undetermined manner be reta ned CHIEF MED CAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MED-CA, EXAMINER prior SIGNATURE the funeral **EXAMINER'S** may Mealth NAME (Type) Tawn, or county) 0 REC D VIII A15ME 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH



1 1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		
	12696 CERTIFICA	ATE OF DEATH	12705
	1. PLACE OF DEATH  o. COUNTY Montgomery MARYLANI		stitution: Residence before admission)
7:	b CITY OR TOWN (If butside corporate limits, write RURAL and give neorest town)  Bethesda  30 days	c. CITY OR TOWN (If outside corporate limits, write Newport News	
	d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress)  The Clinical Center, Bethesda, Marylan	d STREET ADDRESS d 315 69th Street	e IS RESIDENCE ON A FARM? YES \( \square\) NO \( \sqrt{\sq}\sqrt{\sq}}}}}}}\sqrt{\sqrt{\sqrt{\sqrt{\sqrt{\sqrt{\sq}}}}}\sqrt{\sq}\sign}\sqrt{\sq}\sqrt{\sq}\sq}\signt{\sqrt{\sin}\signgta\sq}}\sqrt{\sint{\sin}}}}
î û	3. NAME OF First Middle DECEASED (Type or point) Grace Rose	Lost 4. DATE OF Mirmelstein DEATH Septe	Month Doy Year ember 20 19 67
	S. SEX  6. COLOR OR RACE  7 MARRIED  NEVER MARRIED  DIVORCED  DIVORCED	B. DATE OF BIRTH 9 AGE (In yet lost beethdo	ors F UNDER 1 YEAR FIE UNDER 24 HRS
	100 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWILE None	13 BIRTHPLACE (County & State, or foreign country) Virginia	12 CITIZEN OF WHAT COUNTRY? USA
	13. FATHER'S NAME Louis Banks	14. MOTHER'S MAIDEN NAME Mary Levinson	
	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No Unknown	17 INFORMANT The Medical Recor The Clinical Center, Beth	nesda, Maryland
should be filed with the State Dept. of Health prior to burial, tremation, ar remayal, and in any event, with	1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c)) PART 1. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (o) Respiratory fail		INTERVAL BETWEEN ONSET AND DEATH 4 HOULD'S
	Conditions, if only, which gove nose to immediate couse (o), stating the underlying couse (DE TO  DUE TO  Bronchopneumonia  (b) Sepsis (Staphylococcal) with Endocarditis and/ 5 Day and liver		
1	PART IL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED	s with involvement of lyn To the terminal disease condition given in Part 1	o) 19 WAS AUTOPSY PERFORMED?
	200 ACCIDENT WAS UNDERLYING  OR CONTRIBUTING CAUSE OF CEATH (IF ETHER, NOTIFY MEDICAL EXAMINER)	RED (Enter nature of injury in Port I or Port II of item ?	YES NO
		PLACE OF INJURY (Home, farm, foctory, street, office bldg., etc.)	vn) (County) (State)
	21 I certify that (X) (this haspital) attended the deceased frames aw the deceased alive an 20 Sept. 1967, and	that death accurred at 5:00 M, from cau	ses and an the date stated above
	220 SIGNATURE Jaseph D Croft J	M D PHYS. DIRECTOR PHYS.	22b. DATE SIGNED 20 Sept. 1967
1	22c PHYSIAN'S NAMI(Type) Joseph D. Croft, Jr., MD	22d. ADDRESS The Clinical Institutes of Health	, Bethesda, Md.
$\cap$	230 BURIA, TRÉMATION, 23b. OATE THEREOF 23c NAME OF CEMFTERY BURIA SPECIFY ROSENDAUM	Mem Park Hampton,	or Town) (County) (Stote)  Virginia b REGISTRAR'S SIGNATURE
M	24. FUNERAL DIRECTOR Peningue A France A. G. Jurbyfill & Newport	4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	in landy Judge



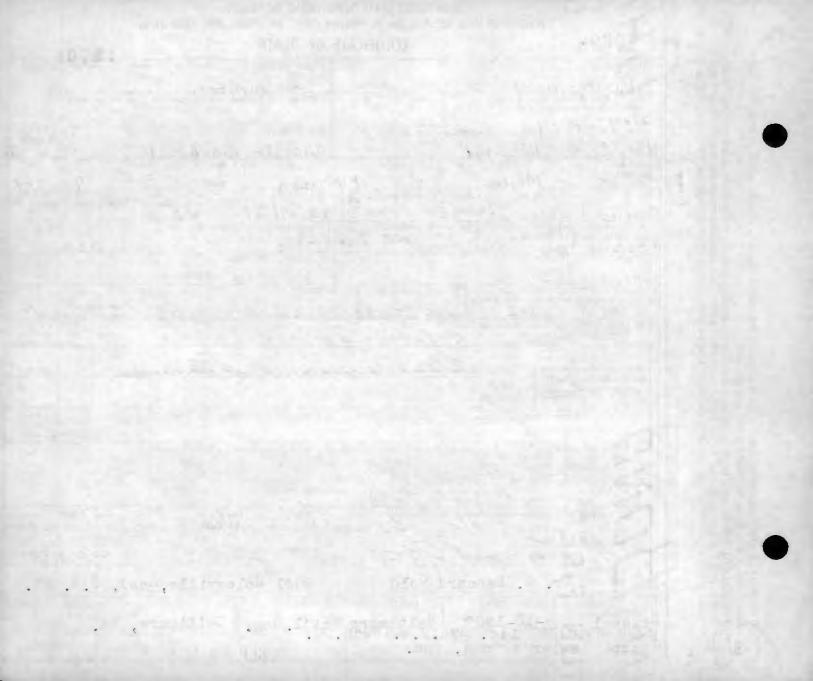
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 12706 physician and campletely filled in by the funeral and 2 has remave carbon papers. Pages 1 and 2 and 2 haus after death. requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY b COUNTY a STATE Montgomery MARYLAND D.C. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C LENGTH OF STAY IN 1b libeaton Washington d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d STREET ADDRESS IS RESIDENCE ON A FARM? University Nursing Home 2520 10th St., N.E. YES NO NAME OF F175 F Middle 4 DATE Lost Manth Day Year DECEASED (Type or print) Jefferson F. dna Moore DEATH S. SEX 9. AGE (In years 1 YEAR IF UNDER 24 ARS 6. COLOR OR RACE 8. DATE OF SIRTH IF UNDER 7. MARRIED **NEVER MARRIED** last birthdov) Months Days Haurs WIDOWED DIVORCED 0/25/1894 Female Negro 100 USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? Housewife Stoney Creek, Viroinia HSA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME the attending phys Juddi Jefferson Rettie Arians IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. /INFORMANT (Yes, no, or unknown) (If yes give war or dates of service) 578-26-2454 No 18. CAUSE OF DEATH (Enter only one couse per line for (a). (b) and (c).
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN **burial-transit** ONSET AND DEATH IMMEDIATE CAUSE (6) DUE TO signed t Conditions, if any, which gave use to immediate couse (a). DUE TO stating the underlying cause Page 4 may be retained by the haspital or attending O FUNERAL DIRECTOR: After this certificate has been as the PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) WAS AUTOPSY PERFORMED? NO YES ģ 20o ACCIDENT WAS UNDERLYING [ 205. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Manth, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f (City or town) (County) (State) Hour a.m. Not While factory, street, office bldg., etc.) of work of work 21. I certify that (I) (this hospital) attended the deceased from 19/2 (that (1) (we) last shamid saw the deceased alive an\_ 19and that death accurred at 1/2 h. M. from causes and an the date stated above 220 SIGNATURE 22b DAPÉ SIGNED M.D DIRECTOR PHYS. 22d ADDRESS 22c PHYSICIAN S directar, po shauld be f NAME (Type) 236. BURIAL/CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d\_LOCATION (City of Town) (County) FUNERAL DIRECTOR VR A15 (4)

MARYLAND STATE DEPARTMENT OF HEALTH





MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12899 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death the funeral I. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission a. COUNTY
Montgomery
b. CITY OR TOWN (froutside corporate limits, o. STATE COUNTY MARYLAND c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 write RURAL and give nearest town papers. Pa hin 72 haurs à = d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? filled YES NO X carban NAME OF Middle 4. DATE Day Year campletely DECEASED Type or print) 19 67 OTTISAN DEATH 6. COLOR OR RACE B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HR 7. MARRIED **NEVER MARRIED** remave hirthdoy) Months Days Hours Min. WIDOWED 29 DIVORCED white and 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or fareign country) during most of working life, even if retired) COUNTRY? Ohio USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME remova CLARK 17. INFORMANT 16. SOCIAL SECURITY NO (Yes, na, of unknown) (If yes give war or dates of service) 0 M. DIEHL-L cremation, 18. CAUSE OF DEATH (Enter only one cause per line for (a), PART 1. DEATH WAS CAUSED BY: INTERVAL BETWEEN (b), and (c).) burial-transit ONSET AND DEATH IMMEDIATE CAUSE (a) signed by attending physician. DUE TO burial, Conditions, if any, which gave rise to immediate cause (a), DUE TO stating the underlying couse as the this certificate has been last. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Health -NO be retained by the haspital ar 20g. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) State Dept. 20e, PLACE OF INJURY (Home, form, 20c, TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED (City or town) (County) (State) Hour a.m. Not While factory, street, office bldg., etc.) After pe 21. I certify that (1) (this hospital)-attended the deceased from 1962 to 1967, that (1) (we) last TO FUNERAL DIRECTOR: 1967, and that death accurred at 10:32AM, from causes and an the date stated above saw the deceased alive an. 22a. SIGNATURE 22b. DATE SIGNED **ATTENDING** STAFF PHYS. director, page 3 shauld be filed v M.D. DIRECTOR PHYS Page 4 may b 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) G. Lennard Colesville . Road . 8641 S.S. Md. 23c. NAME OF CEMETERY OR CREMATORY BURIAL, CREMATION 23b. DATE THEREOF 23d. LOCATION (City or Town) REMOVAL (Specify) Removal 9-13-1967 13-1967 Baltimore Nat'l Wisc. Ave. N. AWRSS Wash. DC. Baltimore 25b REGISTRAR'S SIGNATURE Joseph awler's Sons, "liarles



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12709 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution; Residence before admission) p. COUNTY a. STATE MARYLAND b. CITY OR TOWN (If outside/corporate limits. c. LENGTH OF STAY IN 1h c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) write RURAL and give negrest town). OR ATTENDING PHYSICIAN: The low requires that the deoth certificate be executed within 24 hours in by THESO d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS a IS RESIDENCE ON A FARM? within 72 filled NO Z 3. NAME OF Middle 4. DATE Lost Month Dov Year completely DECEASED Sept. 19 67 JOSEDE (Type or print) event, DEATH 5. SEX IF UNDER I YEAR IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED 9. AGE (In years NEVER MARRIED last birthdoy) Months Hours in ony WIDOWED DIVORCED and 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if refired)
Account ant 10b, KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) INDUSTRY physicion Retired 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME or removol, 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no. or unknown) (If yes give wor or dotes of service) 16. SOCIAL SECURITY NO. 17. INFORMANT 068-09-3327 Same As Item 2. Theressa S.Murray cremation, 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o) CORONARY INTERVAL BETWEEN ONSET AND DEATH CORONARY THRUMBUSIA DUE TO Conditions, if any, which gove TERIO SCLEROSIS rise to immediate couse (a), DUE TO stoting the underlying couse be retained by the hospital or ottending hos been ARKINSUNISM PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPS PERFORMED? for use Health certificate YES NO 20o. ACCIDENT WAS UNDERLYING [ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour 'o.m. Not While factory, street, office hldg., etc.) ot work After of work 21. I certify that (I) (this hospital) attended the deceased from 19 € 2 that (1) (we) lost ta /// 19 67, and that death accurred at O FUNERAL DIRECTOR: saw the deceased alive and 1 A M, fram/causes and an the date stated above 22o\_ SIGNATURE 22b. DATE SIGNED num director, page 3 M.D. DIRECTOR PHYS. 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) DR LAS WISC DONGVAN DUR ASTHESO A 230. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) Burial (Specify) Baltimore, Maryland 9-14-67 Greenmount Cemetery 24. FUNERAL DIRECTOR 250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE PUMPHREY, Bethesda, Maryland Marles 25M 1/67

